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Reader's Guide

Though the names of the officers of the C.N.A. are listed in the Official Directory each month, the persons convening the various national standing and special committees and the members who will be working with them during the coming biennium are listed here for the first time under **Notes from National Office.** It will be very convenient to keep this list where you can find it for ready reference.

Medical science has demonstrated that the typical picture of scarlet fever is only one of the manifestations which may occur when the beta hemolytic streptococcus invades the body. Septic sore throat, caused by the same organism, is rarely reported. Healthy carriers may not present any clinical symptoms yet be a source of infection. A new theory of control is evolving and you will find the informative article by **Dr. John S. Kitching** very illuminating. Dr. Kitching is assistant senior medical health officer and epidemiologist with the Metropolitan Health Committee in Vancouver.

Dr. Frances O. Triggs has had a great deal of experience in personnel work. She was formerly personnel consultant with the American Nurses' Association and prior to that was clinical counsellor at the University of Minnesota and the University of Illinois. She is the author of a textbook on Personnel Work in Schools of Nursing. She has conducted refresher courses in Canada dealing with personnel work. Now she writes for us on adaptations of this work on the graduate nurse level. The program which she suggests should be studied by every nurse — after all *we* are the people who form the "personnel" of nursing in Canada.

Rae Chittick has been teaching the principles of health education to budding teachers for many years. She has seen the results of the health programs that have been functioning all through the years and she feels that somewhere the dynamic spark is lacking which would make those programs effective. Do *they* practise what we preach? Do we ourselves live out in our everyday existence the health practices which we know are the "open sesame" to optimum good health? Should we nurses look at our own health practices, too, with a critical eye? Do *we* practise what we preach?

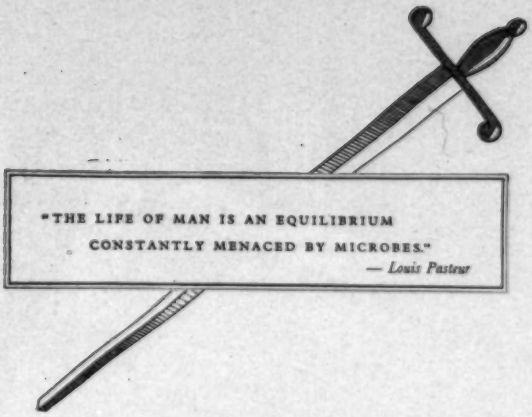
Frances C. Harris, consultant in industrial nursing with the Department of National Health and Welfare, seemed the logical choice for convener when the standing committee on Industrial Nursing was formed in the National Public Health Section. Here she outlines what she hopes her committee will be able to accomplish.

Grace Spice is an instructor in the school of nursing of St. Boniface Hospital. The plan for an instructors' workshop, which was worked out in the M.A.R.N., provides a very useful pattern for other provincial groups.

Some words have a fascination — we tend to roll them around in our mouths just for the feel of them. The title of **Helen Morrison's** study is an illustration. The information which her material contains is even more interesting than the sound of the title. Mrs. Morrison is president of the alumnae association of the University of Alberta Hospital, Edmonton.

Madeleine Flander, who is instructress at Children's Memorial Hospital, Montreal, adapted an assignment sheet which has proven very successful in their hospital. Since the eight-hour day functions for all of the students, the sample shows how duties are assigned and hours regulated.

Brigitte Laliberté, diplômée de l'Hôpital St-Jean-de-Dieu, fit du service durant deux ans au Greystone Park Hospital, N.J. Elle entra au service de santé de la ville de Montréal en 1929 à titre d'infirmière psychologiste à la section d'hygiène mentale et fut promue chef de groupe en 1940. Après avoir suivi des cours spéciaux à McGill de 1940 à 1942, elle continua ses études à l'Université de Columbia, à titre de boursière de la ville de Montréal et obtint son Bc. es Sc. (surveillance en hygiène publique). Depuis elle assuma les fonctions d'assistante de l'infirmière en chef au service de santé. Depuis septembre dernier Mlle Laliberté étudie au Teachers College sous les auspices de la Rockefeller Foundation en vue d'obtenir sa maîtrise es arts.



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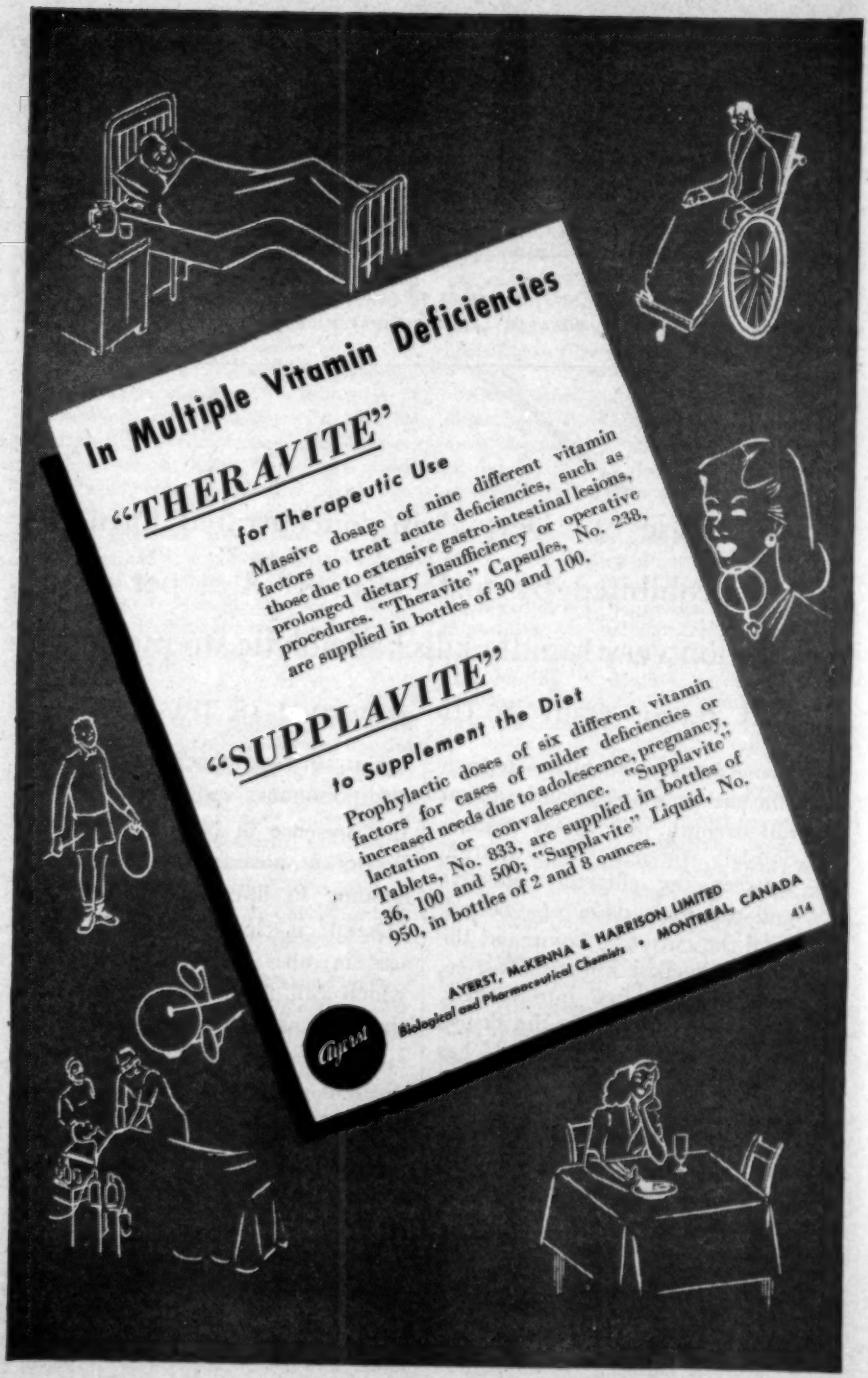
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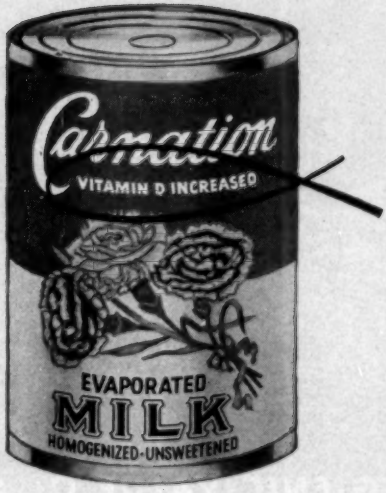

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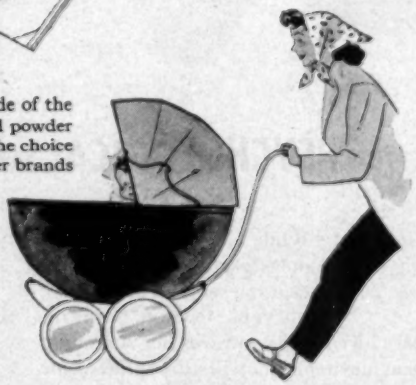

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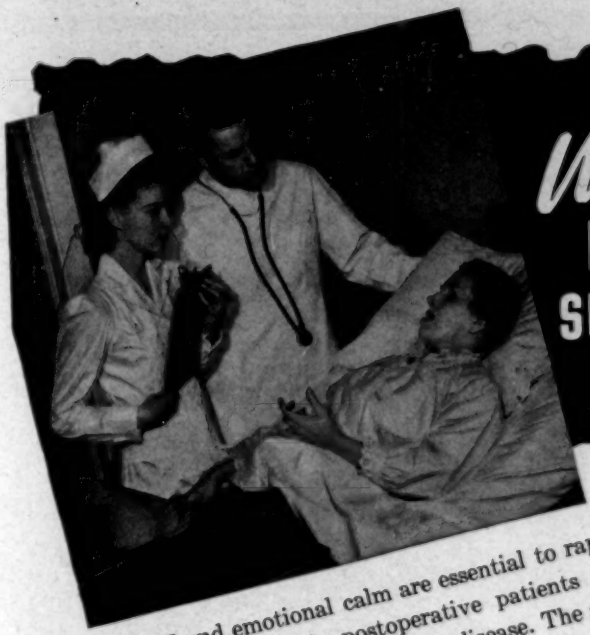

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A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-TWO *NUMBER ELEVEN*

MONTREAL, NOVEMBER, 1946

Should We?

SINCE THE DAYS when our primitive ancestor roved the earth and finally found greater security for himself and his family by living in tribes or clans, habits of action have developed which in time became customs or mores. Children learned to accept the standards in which they were brought up. Now and then, a rugged individualist would rebel against what experience had shown to be desirable for the good of all and he would be ostracized by his fellows. Thus our heritage gives us a strong tendency to adhere to practices and customs which have proven satisfactory. This inclination to resist change is just as strong in most women today as it was five, ten thousand years ago.

All through the ages, too, women were regarded as inferior creatures, as fit only to serve their lordly masters. Not until the nineteenth century was there any appreciable recognition of woman's ability—intellectually, physically, or spiritually. Florence Nightingale was an individualist who managed to throw off the shackles binding women and such was her personality and the value of her contribution that the changes which she effected in the status of women, of nurses, came to be accepted as an acknowledged improvement.

That was eighty-five years ago. In the intervening period, the whole world has been rocked by two catastrophic wars. Women have been called upon to assume more and heavier responsibilities and in every instance they have risen to the challenge. In the last few decades, women have received the franchise, have entered politics, have penetrated into almost every field of activity which previously had been considered the masculine domain. They have formed themselves into study clubs to familiarize themselves with affairs at every level of society. They have joined service clubs to assist those less fortunate than themselves. They have formed strong federations to work towards the achievements of ever higher standards.

We, the nurses of Canada, united our efforts early in this century, through the formation of an association of Canadian nurses, to develop higher professional standards for nurses, to study how to provide better and more complete care for those who were ill, to improve the conditions under which our members would work. The close of World War I saw us struggling for legal recognition for the nursing profession. The privilege which we now proudly enjoy of calling ourselves "Registered Nurses" is ours because our colleagues in every province fought to win us protection under legislative acts.

Today, the registered nurses' associations of all nine provinces are federated in this vigorous national association nearly twenty-five thousand strong. Today, some nurses are turning from the strength of their own organization and seeking guidance and support through non-professional channels. Today, nurses are joining unions.

Has the time come when nurses should join unions in order to work for the economic security which they need and deserve? This question has been in the minds of hundreds of nurses during the past few years. It has brought increasing unrest during recent months when, through union activity, other workers have secured higher wages, vacations with pay, and many other quite laudable improvements. Many nurses are haunted by memories of the bitter years of the depression. They are rebellious at the comparatively meager returns they receive for difficult and exacting professional work. They feel frustrated by what they consider to be the failure of their own association to come to serious grips with personnel practices which have long needed rectifying. They have eagerly accepted the assurances offered by union leaders that a new organization will lead to the promised improvements. Nor is this group of nurses confined entirely to the youngest, most impulsive, and least secure members of the profession. Unions have suddenly become actively interested in recruiting new members from among every branch of nursing.

The time most certainly *has* come when we as a profession should face the question squarely. Should nurses be encouraged to join unions? What are the basic issues involved? Are we being simply averse to change just as our ancestors have been all through the ages? Have the nurses any other alternative than unions in their struggle for economic security?

To clarify our thinking on the problem, let us define the issue clearly. The question is not whether unions, as such, are good or bad. Trade unions in our present-day industrialized society have proven their value as instruments to secure improved living and working conditions through collective bargaining for millions of workers. The unions have demonstrated their interest in the health of the people, in their opportunities for advancement, in their economic security, in raising the standards generally. In other words, unions are attempting to do for the working man, the very same things that the associations of nurses throughout Canada ever since their inception have been striving to accomplish for nurses.

The kernel of the problem seems to be, therefore, can unions serve the nurses better than their own professional associations? Have unions the flexibility to adapt their programs and methods to the nursing group with its vital responsibility for the care of the sick and helpless? Can the union methods be applied without sacrificing any of the dignity, prestige, and high quality of service which is inherent in our professional activity? These are the criteria by which we should study the questions and seek the answers.

The initial tool which unions use is collective bargaining. In 1943, the executive of the Canadian Nurses' Association went on record as approving this principle as applicable to nurses. Since the national body acts in an advisory capacity only, the individual provincial associations endorsed this action and set up their own Labor Relations Committees. On

the recommendation of the national committee, the provincial bodies prepared themselves to serve as bargaining agents for any groups of their members who applied to them. The Registered Nurses Association of the Province of Quebec, for example, has been recognized as the bargaining agent for several groups of nurses. Similarly, all the other provincial associations have set up the form of organization which is most adaptable under their provincial laws. Whatever form this has taken, committees of nurses are ready to serve as bargaining agents if and when the application is made to them. Our laws give nurses, as they give other workers, perfect freedom to choose their bargaining agents by majority vote.

Anticipating such requests, several of the provincial associations have drawn up very far-reaching documents dealing with personnel practices. These have been approved with few changes by the corresponding provincial hospital associations. Armed with these agreements, the nurses' associations are prepared to strive for better working and living conditions for nurses. *But* the request for assistance in securing the implementation of these personnel practices has to come from the individual group of nurses involved. That is the essence of collective bargaining. The provincial associations, which are composed of these same nurses, cannot superimpose their plans on any small group of nurses or hospital or public health organization. A request must be made. Unions would be similarly handicapped. Unions would not have the advantage of the long years of professional association with the public which the nurses' organizations have enjoyed. They would probably be forced to use stronger methods than collective bargaining to gain their objectives.

What are some of these stronger methods? They are being demonstrated to us all over Canada today. Threats of strikes and walkouts, "siphoning off" of key personnel, slow-down, picketing, threatening to disrupt the income or supplies of a hospital—none of these last-resort methods of the trade unions are acceptable to nurses. The professional organization is sensitive to public reaction to these methods and no nurse of true professional caliber would agree quickly to the employment of methods which are so alien to her principles.

Thus changes have been wrought in our own professional organizations. Every facility is attuned to assist individual nurses to reach greater economic security without resort to strong-arm techniques. The weight of opinion of twenty-five thousand nurses is a potent force which has to be reckoned with by every public body. The strength of that chain depends upon the loyal support of every individual member. It is weakened by careless thinking, casual attendance at meetings, and indifference. Should the nurses of Canada join unions? They already belong to a stronger body than any that could now be formed. It is up to the individual nurse to rally to the support of this emerging giantess—the Canadian Nurses' Association, the nine federated provincial associations, the local districts and chapters. Let these bodies prove their strength in working for, fighting for nurses.

—M. E. K.

Coming Events

Event: Special meeting, District 9, R.N.A.P.Q.

Place and Date: Hôtel-Dieu, Quebec City, November 22, 1946. Separate sessions at 2:30 p.m. for (a) Committee of Management; (b) officers of District Associations. General session for all nurses at 8:30 p.m. in the Hôpital du St. Sacrement.

Changing Attitudes in Scarlet Fever Control

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FOR MANY YEARS health departments have dealt rather stringently with scarlet fever in respect to isolation and quarantine. There is an inherent satisfaction and a sense of duty well done when the quarantine placard has been affixed to both front and back door, as much as to say, "Just try and get out of here." The public in general accept quarantine as a proper procedure and one designed to stop disease in its tracks, this, in spite of the fact that scarlet fever and streptococcal disease is ever present, at times in epidemic proportions.

During recent years a changing attitude has developed exemplified by recent changes in isolation and quarantine procedures adopted for the State of California, as follows:

> Respiratory Hemolytic Streptococcal Infections. 1. Scarlet Fever. 2. Other. *Case:* The patient shall be isolated in accordance with recognized isolation techniques until the complete disappearance of inflammation from the nose and throat, and the cessation of discharges from the nose, throat, ears, or suppurating glands, provided that such isolation shall continue for not less than seven days and until clinical recovery. *Contacts:* If the case is properly isolated, quarantine of contacts is not required, except at the discretion of the local health officer. Judicious chemoprophylactic treatment of household contacts under medical supervision may be required by the health officer prior to release.

We may deduce from this statement, first, that scarlet fever is recognized as but one of the respiratory hemolytic streptococcal infections for which control measures are desirable, losing its priority as a distinctive clinical entity. Again, a minimum limit of seven days' isolation for the patient and until clinical recovery represents a drastic cut from the minimum limits of three, four, and five weeks which are enforced throughout different Canadian provinces. On the other hand, an attempt is made to set minimum standards for the control of all respiratory hemolytic streptococcal infections which measures have hitherto been negligible, rather than for one only, namely, scarlet fever. This principle is reasonable as it is well-recognized that serious complications of a suppurative and non-suppurative nature follow in the wake of all hemolytic streptococcal infections, e.g., otitis media and rheumatic fever syndromes.

Quarantine under these amended regulations is left to the discretion of the local health officer which must be a body blow to the exponents of rigid quarantine, but which, on second thought, appears to have some justification. There never has been any regulation covering all points in public health practice which operates to the satisfaction of all health officers. This has been particularly true in the case of scarlet fever. Therefore, it is with satisfaction that one notes the words "except at the discretion of the local health officer." This should, however, not be interpreted as an excuse for doing nothing. Regulations should guide as well as enforce.

The precedent for this change has been established by the recommendation of the Sub-committee on Communicable Disease Control of the American Public Health Association and expressed in the "Control of Communicable Diseases, 1945, 6th Edition." Two broad groups of streptococcal infection are mentioned —respiratory and other than respiratory. Scarlet fever belongs to the first group and is associated with streptococcal sore throat, streptococcal nasopharyngitis, streptococcal tonsillitis, and septic sore throat. Control measures for these conditions suggest that for uncomplicated cases the period of communicability should be completed within fourteen days and quarantine (presumably of contacts) is not indicated.

Before we give in too quickly to

these recommendations, it may be worthwhile to examine some of the cardinal features of hemolytic streptococcal infections.

What is scarlet fever? It is an acute communicable disease of which the distinguishing features are sore throat, fever, and rash. A true scarlet fever rash is typically erythematous, punctiform on the body, not so on the face, with desquamative changes occurring on the tongue early in the disease and on the body later.

What is streptococcal sore throat? According to the Sub-committee's definition: "Characteristic manifestations are sore throat and fever, sudden in onset and accompanied by systemic manifestations of an acute infection. The pharyngeal mucosa or tonsils are injected or coated with exudate." The differential diagnosis between scarlet fever and streptococcal sore throat is not always so easy, as many cases with streptococcal sore throat show transient erythemas, not always characteristic of scarlet fever. If, as we believe, the origin of the two conditions is the same, separation of the two groups is merely academic.

The *Beta Hemolytic Streptococcus* is generally accepted as the causal organism of respiratory streptococcal infections, including scarlet fever. Human pathogenic strains belong to group A (Lancefield) and there are over forty types (Griffiths), the majority of which may in susceptible individuals give rise to morbid processes including scarlet fever.

The beta hemolytic streptococcus has two actions. First, it may invade tissues and set up complications of a septic nature, e.g., otitis media. Secondly, many strains elaborate an erythrogenic toxin, the external evidence of its action being a rash. Internal changes also occur and many of the serious complications such as nephritis, myocarditis, and arthritis are due to this toxin. Once a person becomes infected, several things may happen:

1. Nothing at all. If a person is resistant because of the presence of personal antibacterial and antitoxic immunity, the organism conceivably may occasion little or no damage. Such persons, usually adults, are common in every community and may be classified as healthy carriers.

2. A sore throat without rash may develop with exudative changes in the faucial area. This person is presumably resistant to the toxic factor but not to the invasive factor.

3. Scarlet fever may develop, indicating a lack of resistance to both factors.

4. Modified rashes and constitutional reactions may occur, depending upon individual resistance and the invasive and toxigenic power of the organism.

One type of streptococcus may occasion any one of the above conditions in different individuals at the same time. Also, it is well recognized that, while second attacks of true scarlet fever are rare, the exposed individual may be liable to repeated attacks of streptococcal sore throat later on. Antitoxic immunity is not necessarily a guarantee of antibacterial immunity. Again, there is reason to believe that streptococci might not at all times be virulent in the sense of producing disease. Hartley, *et al*, report the absence of clinical disease in spite of a high incidence of carriers of group A hemolytic streptococci type II in a home for crippled children. The carrier rate was never below 25 per cent and once nearly 90 per cent.

In our approach to control measures it must be realized that not all types have the same capacity for producing erythrogenic toxin and thus such types might be expected to produce less of the picture of scarlet fever when active in the body. We have all seen this happen. At times there is an epidemic of scarlet fever and at other times a high incidence of sore throats and tonsillitis.

Scarlet fever, as such, is usually more frequent in younger age groups than in adults. Infants from six months of age and young children usually have little or no antibacterial or antitoxic immunity and thus are more liable to develop scarlet fever. While antitoxic immunity may be developed, either through natural or artificial means (scarlet fever immunization), the same does not hold

for antibacterial immunity and so a person who has had scarlet fever or who has been immunized may develop repeated sore throats or other streptococcal infections. This is indeed a serious situation and one which up to the present we have made little headway in preventing. Second attacks of scarlet fever are on record and there is evidence that among family groups and in isolation wards, several types of toxigenic streptococci may be present and complications and so-called relapses may be due to a different type altogether.

CONTROL MEASURES

1. *Diagnosis:* It is not always easy to diagnose scarlet fever. If the diagnosis depends entirely upon the rash one may often be misled. The intensity of the eruption and distribution varies in individuals and erythematous rashes are common apart from those due to the streptococcus. You will recall that many of the acute infective diseases have prodromal erythematous rashes and such rashes are not unknown in staphylococcal infections. Again, desquamation in convalescence cannot always be depended upon. Any rash on the body is liable to be followed by desquamative changes, either local or widely distributed. However, a history of acute sore throat with fever and rash always makes one suspicious of scarlet fever. An infected throat, with or without tonsillar exudate, a macular rash across the soft palate, petechiae and early desquamative changes on the tongue with a resultant "strawberry tongue" are among the early diagnostic points. In many cases the throat signs and symptoms are mild, and erythemas of varying intensity may be found on the body. In such cases a doubt may arise whether the condition is scarlet fever.

However, considering the broader picture of respiratory hemolytic streptococcal infections there are certain laboratory and diagnostic criteria which are useful in arriving at a diagnosis. Keith and Carpenter[3] have offered some useful suggestions, summarized as follows:

(a) A positive throat swab for the hemolytic streptococcus Lancefield A; (b) the history of a sudden onset with headache, sore throat, and little or no cough; (c) red throat with exudate and enlarged cervical glands; if exudate was present there was four times the chance that the infection was due to the hemolytic streptococcus than if no exudate was found; (d) a white blood count of 12,000 or over. (This was found in 70 per cent of the cases proven to be due to the hemolytic streptococcus.)

Keith and Carpenter also state: "In all probability two-thirds of patients with upper respiratory illness with hemolytic streptococci Lancefield A in their throats are suffering from an infection from that organism and the other third are merely carriers with some other infection causing their symptoms." This is supported by evidence that antibodies, determined by the antistreptolysin titre, developed in the majority of cases where severe infections occurred and that such antibodies did not develop when infection was attributed to other than the streptococcus. While laboratory diagnostic procedures for hemolytic streptococcal infections in public health practice are not sufficiently developed to undertake such a routine for all suspect cases, yet it is felt that the laboratory has a very definite place in control measures. For instance we would like to know if our cases are suffering from group A infection (anywhere from 20 to 50 per cent of strains isolated may be other than group A). Typing of strains is a difficult technical procedure and at present has limited practical application. The taking of cultures from inflamed throats, particularly when exudate is present, is most useful especially when diphtheria is present in the community. In our recent experience not a few reports have returned positive for diphtheria. While the taking of cultures is useful in diagnosis, such should not be done for release. By insisting on release cultures for cases and especially contacts we would be manifestly unfair as well as ignoring the number of healthy carriers present in the community which seldom falls below 5 per cent.

The Dick test has little place in the diagnosis of respiratory streptococcus infections. Schwentker, *et al*[4] report that in sixty-six contacts who became infected with type 10 streptococcus, and yet had developed no illness, about half were Dick positive and half Dick negative. Again, immunity does not necessarily depend on the presence or absence of antitoxin but often on the presence or absence of antibacterial factors. The Dick test has a broad value in determining group resistance to toxigenic factors, especially where active immunization against scarlet fever is contemplated.

2. *Reporting:* Of all the respiratory streptococcus infections there is no doubt that scarlet fever is best reported. In the presence of milk-borne epidemics, septic sore throat is usually reported. Otherwise we have no means of assessing at any given time the amount of acute streptococcal disease. This is the more important when we remember that the same streptococcus may produce scarlet fever in one person and a sore throat, *sine eruptione*, in another. Except where there are public health services in schools, institutions, industries, camps, etc., we have very little idea of the concomitant incidence of respiratory streptococcal infections. The University of British Columbia, Vancouver, has a student health service. During the 1943-44 session 2,056 students reported with mild colds and nasopharyngitis. (Some students, of course, reported more than one attack.) Time lost by this group was 1,791 days. At the same time 13 students were diagnosed streptococcal sore throat and this group lost 57 days. But 5 students developed scarlet fever and they were absent a total of 131 days. The student enrolment was approximately 2,500. The mere reporting of scarlet fever alone achieves but a limited objective and it behooves health departments to study ways and means of instituting a uniform reporting service.

3. *Isolation and quarantine:* By isolating cases of scarlet fever only and quarantining contacts we are again attempting to control but a small part of the general picture. Isolation of the case is necessary to prevent the spread of infection to others and implies that the case should receive treatment. However, spread usually occurs before the case is isolated and all that isolation can do is to prevent further spread. The end of isolation must not be confused with clinical recovery. It does not mean that Johnny may go back to school after one week or any set time. The attending physician should be the person who decides when recovery is complete and when the patient may safely take his place in the community again.

The termination of isolation infers to some that from that time on the case is presumably non-infectious. This is a most difficult point to decide and no rigid period can ever be set which guarantees freedom from infection. The three or four weeks' isolation required by most provinces for scarlet fever, while stringent in many cases, does provide a factor of safety, both from the public health and the clinical standpoint. Again, no isolation provisions for other respiratory streptococcal conditions suggests that a vast number of sick persons are not receiving adequate treatment, are not being careful, and are disseminating infection everywhere. True many cases of respiratory streptococcal infection are improved in a few days and after a week there may be little or no evidence of clinical activity. One must remember, however, that complications have a habit of developing during the second and even third weeks of illness and every case should again be examined not less than a month after onset. Where there are sufficient physicians, public health officers, and nurses available to report all cases of streptococcal disease and follow through isolation, nursing and treatment services, then latitude may reasonably be allowed in determining the period of isolation and recovery. This implies a complete community and family service. Communities

which have this service are indeed fortunate but too often such facilities are lacking, too spread out and not centralized, and, at best, a limited attempt to control the problem can be achieved. Under these circumstances control measures must of necessity be more stringent and less latitude in regulatory procedures allowed. Thus there can hardly be a uniform policy for all, except in those localities well staffed and serviced, where all cases may be followed up with a minimum of interference in the economic life of the community.

This brings us to the quarantine of contacts. By quarantining contacts of scarlet fever only we are emphasizing but one aspect of the problem. By imposing rigid quarantine on all family contacts of scarlet fever we are being unfair to many adults. In Vancouver, in 1942, the secondary attack rate for contacts under eighteen years of age was 6.1 per cent as opposed to 0.5 per cent over eighteen. This, of course, does not mean that adult contacts did not develop their fair share of sore throats, the amount of which, unfortunately, was not accurately determined. Most regulations require the exclusion of food-handlers from work for a period of a week after last contacts with scarlet fever and there is good reason for this. There is just as much reason for a food-handler, a contact of streptococcal sore throat, to be excluded from work for a like period. How could we ever enforce this when primary sources are not specifically known? Again, there is a good chance that most persons in an urban community are at times healthy carriers of hemolytic streptococci, food-handlers included. Therefore, strict application of quarantine procedures for all contacts is impractical and as there appears to be little likelihood of eradicating streptococcal infection in this way, our attempts at control should centre on the sick rather than on healthy contacts. If the public could be educated to this concept, all persons with a streptococcal sore throat would be obliged to stay away from work until clinical recovery, with perhaps quarantine at the discretion of the local health authority for food-handlers, school teachers, and young children depending upon local conditions and the severity of the disease present.

A school program whereby every child with a sore throat would be excluded until clinical recovery, and a routine inspection of home contacts and classrooms which have had a high incidence of hemolytic streptococcal infection, would be eminently more practical and economically sound than (a) closing schools; (b) excluding only contacts of scarlet fever and not following through every case of suspect streptococcus infection. If such could be done there would be less need for quarantine. A practical scheme for the control of human streptococcal infection might be as follows:

(a) Prompt and adequate isolation of all cases and suspect cases until clinical recovery; isolation infers removal from contact with the rest of the family.

(b) Observation of all family contacts for at least one week following last contact with case.

(c) Segregation and isolation, if necessary, of contacts showing any evidence of streptococcal infection.

(d) As milk and milk products are the most common vehicles for the spread of streptococcal infections, apart from man himself, all milk destined for human consumption should be pasteurized.

(e) Placarding should be limited to the premises of recalcitrant cases, but the power to placard, isolate, and quarantine should still be retained by the local health authority.

4. *Treatment:* There are arguments both pro and con against the routine use of "sulpha" drugs in the treatment of hemolytic streptococcal infections. It is felt that most practitioners have used "sulpha" with the hope of avoiding septic complications. There is evidence that under such treatment there is a reduction in the number of streptococci present in the nose and throat. Rubenstein and Foley[5], however, suggest that the administration of sulphonamides may lead to a "cultural latency" which is followed after an interval by a re-

appearance of the causative organism. This may be due to the fact that the action of these drugs is bacteriostatic rather than bactericidal and, further, that the routine use of these drugs may result in the development of drug resistant strains of streptococci. Penicillin is also widely used in the treatment of streptococcal infections. Keith, *et al*[6] report that of cases treated with penicillin, 30 per cent only harbored hemolytic streptococcus (A) at the end of a week while 100 per cent of controls were still positive after this time. Flushed with excellent results obtained through the use of sulphonamides and penicillin many physicians overlook the value of scarlet fever antitoxin which still has a specific value and indication in acute toxic scarlet fever. There is little doubt that adequate treatment will result in a shorter fastigium, fewer complications, and in many cases a diminution in the numbers of organisms present in the throat. Therefore, a properly treated case should be in the main less dangerous as a spreader of infection than one receiving no treatment.

5. *Prophylaxis:* In closed institutions, army camps, etc., there are numerous examples that "sulpha" prophylaxis under controlled conditions will reduce the incidence of secondary infections among contacts. Unfortunately, there is little information regarding its usefulness in routine family practice. Physicians recognize the danger of the indiscriminate use of "sulpha" and certainly it is not recommended that health departments dispense prophylactic "sulpha" pills to household contacts unless prepared to assume responsibility for untoward reactions. We have no fault to find with the family physician who orders them and carefully watches results. In camps and boarding schools where hemolytic streptococcal infection is present in epidemic form one might be censured for not giving them and rightly so, but the indiscriminate dispensing of these drugs to contacts is to be deplored unless adequate precautions are taken.

Scarlet fever toxin has a recognized place in preventing scarlet fever. Records of attack among controlled groups, such as nursing schools, confirm this. In Vancouver, we recommend active immunization against scarlet fever following the first birthday. The young preschool groups show the highest Dick positive rates and are very susceptible to scarlet fever. Therefore, it seems reasonable if any mass immunization is attempted that it begin with the preschool groups. By decreasing the incidence of scarlet fever in the young it is hoped that, through natural immunizing processes, the antitoxic resistance of the individual will be built up as he gets older. Unfortunately, the value of active immunization is limited and does not provide protection against all forms of respiratory streptococcal infection. It provides antitoxic rather than antibacterial resistance and does not appear to prevent the invasion of tissues with the hemolytic streptococcus.

While recognizing that no specific preventions are available to control the total respiratory streptococcal picture, it would seem reasonable to utilize such procedures as are practical to limit the spread and assure that the sufferers receive adequate treatment. Streptococcal respiratory disease and its complications is one of the principal causes of disability in military establishments. In civilian practice we see its effect in rheumatic and other processes. Acute rheumatic fever and chronic valvular heart disease are, next to tuberculosis, the most frequent cause of death due to infectious disease among children and young adults.

The nursing profession has a direct responsibility in this program. In hospitals, nurses should report the early symptoms and signs of streptococcal complications, e.g., rashes, sore throats, earache, glandular swellings, unexplained fevers, cloudy urine. Private duty nurses in the home, Victorian Order of Nurses, etc., should be on the lookout for such complications and report them to the attending physician. Public health nurses in schools, industry, and the community

should ever be vigilant and report suspicious signs immediately to the responsible authority. A public health nursing program, fully developed, should include home visiting and follow-up to:

(a) Instruct families in isolation and nursing techniques.

(b) See that physicians' instructions are being carried out.

(c) Report the development of any suggestive illness among family contacts.

To date we have concentrated our efforts mainly on scarlet fever to the exclusion of other types of respiratory streptococcal infection. To achieve a balance we should include all types of respiratory streptococcal infection and, incidentally, rheumatic fever among our reportable diseases, and attempt to carry out a program of at least limited control.

Several obstacles will have to be faced. The indifference of the public in general to a sore throat. Many individuals, even with fever, continue to work, and too often we are apt to dismiss them lightly. If any instructions are given, they may be, "Oh, you should go home for a day or so—nothing specific—use a throat gargle." Very little education is ever attempted to explain the need for treatment and the potential hazard to contacts. This indifference will have to be overcome and while it may be difficult and perhaps impossible to insist on a 7-day isolation regime, yet it is our responsibility as health educators to insist that such sufferers shall not be permitted to mingle with their fellows at least until after clinical recovery as determined by a physician. If a rash is present or even a hint of scarlet fever the public is resigned and quite complacently accepts long isolation and quarantine periods as fit and proper. Our approach must be revised and while not suddenly relaxing control measures for scarlet fever, the objective should be to implement control measures for other respiratory streptococcal infections. Educational channels must be used. All cracks in sanitation, such as the use of unpasteurized milk, must be closed.

Hygiene officers in military establishments have successfully limited the spread of respiratory streptococcal infections by approved methods. It is our duty to translate such measures into civilian practice.

The California State Board of Health is to be commended in starting such a program and its results will be noted with interest.

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4. Schwentker, F. F., Janney, J. H. and Gordon, J. E.; The Epidemiology of Scarlet Fever; *American Journal of Hygiene*, 1943, 38:27.

5. Rubenstein, A. D. and Foley, G. E.; The Effect of Chemotherapy on the Duration of the Carrier State following Scarlet Fever; *New England Journal of Medicine*, 1945, 233:315.

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Carrot Tops

Carrot tops are not so useful as they are attractive. This is the conclusion reached by experimenters at Cornell University. When carrots were kept seven days at room temperature, topped carrots lost 40 per cent less moisture than carrots with tops attached. Experimenters showed no significant food loss resulted from removal of tops. The loose carrots lost none of their carotene content on storage and they had a much better appearance.

— (*American*) *Nutrition Notes*

Personnel Practices in the Nursing Profession

FRANCES ORALIND TRIGGS

ORGANIZATIONS and institutions in general by which nurses are employed have been slow to consider the conditions under which they work. This statement does not imply criticism of the employers, many of whom are nurses too. There are a number of reasons why so little attention has been given to the nurse employee and her welfare. First among these reasons may be the fact that most of the organizations which employ nurses have service as their main objective. As a result, the welfare of those served is often given more attention that that of those who serve. Second among these factors, which are not ranked in the order of their importance, might be mentioned the nature of the financial status of the organizations for which nurses work. Taken as a whole, a large percentage of these organizations were philanthropic in their origin. Many are now tax-supported agencies. This fact, coupled with the fact that most of them are mainly service organizations, means that as small a proportion as possible of their budgets is spent on salaries, living conditions and employee welfare. Third, it should be remembered that the very system under which nurses have been educated has had a tendency to stress to the extent of ingraining into these persons when students that theirs is a service profession; that their welfare is secondary. In the past, those who did not agree to this philosophy frequently did not continue in the curriculum long enough to be graduated. Fourth, nurses are known to be inarticulate as a group when compared to persons of other professions. Whether this is true because of selection or by reason of their education is not known; probably both.

There are probably many other reasons we could enumerate for the lack of consideration which has been given to the welfare of nurse workers as individuals, but as trends are studied it is evident that whatever the reasons have been in the past, the situation is changing, probably partly at least because of the increased emphasis on employee welfare wherever employer-employee relationships exist. The trend now is toward having the relationship defined in an organized plan known as the statement of personnel practices of the institution. This plan is often printed and given to employees when they are hired.

Historically, however, practices were not always set up as an organized plan by the employer and the employees to be used as a guide in matters affecting the welfare of both. The relationship was often a paternalistic one, but even though the employer had only a few workers it was expected, though the practice was not always followed, that he would have the interests of the employees at heart. There were few objectively tried measures which could be applied. But as organizations became larger and more persons were employed by one industry or institution, these employer-employee relations became more involved and less to be taken for granted. Organizations of employees began to arise which came to be known as unions, and their tool to ensure consideration of their welfare became the strike. This whole transition from a largely agrarian and feudalistic to an industrial society is a fascinating study in itself and one which may be followed through technical literature or through novels and stories such as "Dragonwyck" and "Valley of Decision."

This whole trend has had its effect on nursing as an employee group. Many factors are now involved. For instance, we find today many variations of the union pattern growing up in the nursing profession and we have some nurses belonging to unions. We have the profession itself acting

as the collective bargaining agent and signing contracts for its members. We also have those who say nursing is a profession — a service profession — and, therefore, cannot justifiably utilize union tactics to gain consideration for itself; that its responsibility, first and foremost, is service to those who are ill and the prevention of illness in those who are well. These persons call the attention of their fellows to the fact that germs and accidents and births and deaths will not wait while nurses strike for higher wages or better working and living conditions. They urge that these matters be considered jointly by employers and employees, that it be recognized that the aim and objective of the organization or agency employing nurses is also the aim and objective of every nurse employed by it, and that those aims and objectives will be best attained by giving her the living and working conditions under which there is the least unnecessary physical and mental strain, that she may work most efficiently.

While this experimental condition exists, much can be done by nurses themselves, whether employers or employees, to relieve present inequalities and stablize personnel practices for their groups. They can study themselves as individuals to determine under what conditions they can work most efficiently and will be most content, for freedom from mental and physical strain makes for more efficient work. They can study their jobs to determine what attributes are required that those jobs may be most efficiently done. And they can study techniques for making as objective as possible the selection of those nurses who can do each type of job most successfully. In doing so they will learn to use objective techniques to study the individual nurse, to determine where and how she can get her greatest satisfaction from her work, and at the same time make the greatest contribution to her profession. They can study working and living conditions and learn to make them such that they will be most challenging to further professional and personal growth.

Let us examine some of the factors which are involved in this whole picture.

Democracy is built on the philosophy that all men and women have certain "inalienable rights," which philosophy presupposes certain "inalienable responsibilities." This applies equally in the workaday world to employers and employees. The conditions under which an individual lives and works affect greatly the extent to which he attains these "inalienable rights" and the extent to which he contributes to the "rights" of those whom his life affects; for in our society, at least as it exists today, the interplay between individuals, communities, and nations is so great that no nation, no community, and no individual can live unto itself alone.

Psychology has shown us that members of the human race are alike in some ways and different in some ways. They are alike in that they are all alive and wherever life exists its continuation makes certain elementary demands: food, drink, and protection from the elements. The fact that all are members of the same species also makes for certain likenesses, especially those due to inheritance and thus human beings have similar physical and mental endowments. Also, due to similarity of the environment in which these inherited traits develop individuals show great similarity in their expression of their endowment.

To the extent to which individuals are alike their basic needs are likely to be similar; to the extent they differ, their basic needs may differ. It is important, therefore, to examine the differences as well as the similarities which exist between human beings. This can be done especially after learning how to use certain tools to measure these differences, for actually while similarities are so great they are often obvious to the naked eye, differences between individuals though important may be small and thus fine tools may be needed to recognize them. Let us begin by exam-

ining the obvious ways in which individuals are similar.

Probably if we were to ask a large number of individuals what they desire more than anything else in life, they would almost to a person answer "security." What is this mysterious something known as security? In its simple form, security is the ability to meet life's demands as they occur. Anything that threatens the ability to do so threatens one's security. Economically speaking, money is one of society's greatest sources of security, for many of life's needs as they arise can be purchased with money. Thus a bank account, a well-paying job, and investments of various sorts such as insurance in its several forms, stocks and bonds, lands, etc., all are forms of security. So is education for, in a normal labor market, education to a certain extent can be traded for money.

Health is a form of security for basic to earning power is one's ability to "sell" his personal capital, his skill or service, directly or secondarily, through goods which have been obtained through the application of those skills bringing money in return. Ill health is, in fact, one of the greatest threats to security there is and, as all nurses know, one which proper safeguards can do much to prevent.

Familiarity of surroundings contributes to security for thus one may predict what requirements will be made of him. It is possible that one may become so familiar with these requirements, however, that he may become bored and look for more novel surroundings.

Asked again what they desired, many persons would indicate a strong wish for recognition. This may be attained in a number of ways. A raise in salary is a form of recognition, as is praise in its various expressions. If recognition is not attained in a socially acceptable manner, the lack of it may be such a potent force that individuals may deliberately act in socially unacceptable ways to gain it.

To love and be loved is a desire closely related to both recognition and security. To be needed is a potent force, as is a feeling of belonging to one's group and the resulting sense of loyalty to it.

How can employer-employee relations take into account the human desires and needs just mentioned in such a way that they will be satisfied to the largest extent possible through work, whatever that work may be, in this case by the application of nursing and related skills? It is the "personnel practices" of the organization or agency for which the nurse works which will define the manner in which these factors will be recognized and satisfied.

The personnel policies of any organization are the blue-prints describing the manner in which employees are chosen, the work which they do, and the conditions under which they are retained, promoted, transferred, may resign, retire, or are dismissed. Obtaining and retaining the most competent employees to handle the work is the end result of the personnel policies of any organization or institution. But it should be remembered that the competence of employees is directly related to the extent to which conditions of employment satisfy the basic needs of the employees. And, as pointed out earlier, all of these basic needs are not of a monetary nature. This was indicated by the Bixlers[1] when they wrote, "A profession strives to compensate its practitioners by providing freedom of action, opportunity for professional growth and economic security." In other words, personnel practices which define salary (and perhaps hours of work) only are inadequate. What is implied in "freedom of action," "opportunity for professional growth," and "economic security" in the nursing profession? The latter two phrases would seem actually to be means toward obtaining the first. Let us consider what might be included in "freedom of action."

Under "freedom of action" a nurse

1. Bixler, Genevieve Knight and Bixler, Roy White. "The Professional Status of Nursing," *American Journal of Nursing*, Vol. 45, Sept. 1945, pp. 730-735.

might include the expectation that through her position effectual use will be made of her professional skill, and her qualities of leadership in setting up professional standards both in the actual practice of her profession and in the profession as a whole; that she will be able to continue her professional education, both on the job and through provision for leaves of absence and sabbatical leaves; that she can contribute to, and be a part of, a social setting which will be satisfying to her when she is relieved for the moment of her professional responsibilites; that her environment at all times will be such as to contribute to the development and maintenance of emotional stability, sound physical development and personal growth.

What should a nurse look for in a position which will assure her "freedom of action," as defined?

1. She must inform herself of the duties of her position and her responsibilities so that she may be able to evaluate her own work and gain the satisfaction which comes from a "job well done." She must know administrative lines of authority in the organization to which she is responsible, and her own supervisory responsibilities, that she may be able to follow and help to improve smooth administrative organization.

2. She must ascertain what compensation she may expect and how it compares with compensation in positions of like responsibility and those requiring similar education and training. She must also know the cost of living in relation to her expected compensation. She should be informed concerning the salary advancement policy of the organization.

3. She should be informed on what basis employees are selected for positions with the organization. Objective selection requires that the job to be done be clearly defined. It is then possible to determine what educational and experiential background it is necessary for a future employee to have. It is also possible to set up "samples of behavior" from the actual job, which may become standardized tests which those who are interested in applying for the position may take. On the basis of the scores on such a test and on the basis of a study of credentials which should include an application blank which gives factual data concerning the applicant, the record concerning past educational work, and references from former employers, it is possible to evaluate applicants and choose quite objectively those who would seem to be best qualified for the position, and for whom prediction of success on the job is good. Usually an interview is advantageous both to employee and employer before any final decision is made.

4. The nurse should have information concerning and understand the reason for the orientation and probationary period of her employment when she is considering a position. The probationary period of perhaps six months, or some other stated period of time, should be a part of the selection process. This period allows for a check on judgment by the employer and allows the employee to demonstrate her ability on the job. The probationary period should be a period of orientation and supervised experience as she works. The new employee should expect and welcome this period of orientation during which she sees, as a part of the total service of the organization, her duties as described by the job description on which she accepted the position. Too often the orientation period is overlooked and the nurse is put into the job to flounder and learn or flounder and fail.

5. Throughout the nurse's employment on the job, she should also expect that there would be opportunities for in-service training, either through formal continuation study courses or through informal contact with supervisors and specially trained personnel. Such in-service training is one opportunity for furthering professional growth.

6. The service or efficiency rating system of the institution should be explained to the nurse when she is

employed. Usually at the end of the probation period, there is the first formal evaluation of the extent to which the nurse has been successful on the job as described in the job description which she was given when considering employment in the position. It is on the basis of this evaluation, formally prepared and discussed with the employee, that she either becomes a permanent member of the staff, or is considered an unpromising employee and, therefore, tried on some other position more appropriate to her abilities or asked to leave the staff. The data included on the service rating, as made out by the supervisor, should at no time come as a surprise to the employee. If she has had the opportunity for frequent contact with her supervisor, she will have been informed continually of the progress which she is considered to have made. Also, on the basis of the job description, she will be able to evaluate somewhat on her own the progress which she has made and the extent of her ability to do this job and to do it well. The service rating then becomes an objective way of measuring progress on the job and, therefore, becomes one basis for promotion. It is, at the same time, a supervisory tool and acts as an aid to good administrative procedure. It also aids the employer to utilize fully the employee's ability.

7. The nurse should investigate opportunities for promotion in the institution with which she is considering employment. It is essential that all employees feel that they have a fair opportunity to be promoted along with others who are competing for promotion. It is natural that a nurse wants to feel that she is making progress in her profession. She will often leave one institution and go to another for such advancement if she does not see the opportunity for promotion in the institution where she is employed. Also it should be possible for the employee to see lines of transfer from one experience to another that she may broaden her background. At times transfer would also include promotion.

8. The nurse should be fully informed concerning the internal personnel policies which will affect her, such as leaves of absences of various kinds, sick leave, educational and sabbatical leaves and leaves without pay, compensation in case of injury, hours of work, vacation, discipline, retirement, separation by resignation or removal, health requirements and practices, and so forth, of the institution with which she is considering employment. If these are set out objectively, the employee and the employer are very unlikely to be in disagreement about them. If they are not clearly understood and objectively set forth, questions and some disagreement are very likely to arise.

9. The nurse should know by what means a question will be given consideration should disagreement arise concerning matters pertinent to her efficiency and welfare on the job. There are two types of plans which may be set up for this purpose. First, there may be a joint committee of employees and the employer on personnel practices in the institution. This committee might well accept suggestions directly from both the employer and the employees, consider them at their meetings, and report back on action taken. Also, there may be what might be called an "appeals body" or a personal adjustment committee, which could be reached for discussion of any question that might arise concerning interpretation of personnel policies. This committee may be a standing committee, or a committee may be convened at the signed request of any employee or the employer. It should have on it a person representing the employee, a person representing the employer, and one person totally unbiased by any responsibility to the employee or employer. It is to be expected that some grievances will arise no matter how objectively the personnel practices are stated. If there is a medium through which to handle these grievances, they will often fade as quickly as they came.

If they cannot be objectively discussed, they are likely to mushroom and increase out of all proportion to their importance. For instance, in a recent strike, it was said that on investigation it was found that 38 out of 42 of the grievances presented as a basis for the strike were individual grievances, and that when these individual grievances were settled the four other seemingly important points disappeared very quickly. If there had been machinery to handle this lengthy list of grievances as they arose, it would have made a great deal of difference probably in the calling of the strike.

Living conditions and costs of living should be investigated especially in the field of nursing. It is necessary for the nurse to know what her "take home pay" will be. For instance, if she is to be required to "live in," then she should know exactly how much will be taken out of her salary to pay for living in; also, how much will go to pay for meals, laundry, retirement, unemployment compensation or any other such costs as may be included. If she does "live in" she should also investigate and see personally, if possible, the conditions under which she is going to live. It has been strongly recommended that nurses "live out." When she lives " in" her contacts are limited. It is felt that there is much less likelihood of personal pettiness arising if a nurse can have a normal living situation such as other professional people have.

It is well to have the personnel practices clearly outlined and handed to the employees in printed form so that they can examine and study them before they enter upon employment, and so that they can refer to them when questions arise among the group. There should be a person in every organization who has as his or her special responsibility the clarification and administration of the personnel policies. These policies may be revised as need arises by joint agreement between employer and employees. The manual describing the personnel practices will have to be revised as changes are agreed upon. Every nurse before she becomes a permanent employee of an organization, agency, or institution should demonstrate her mastery of the policies as set forth in the manual.

In summary, we might outline the table of contents of such a manual: description and classification of positions in the organization with compensation range and avenues of promotion; organization of administrative authority; methods of selecting employees; internal personnel practices including orientation, in-service training, leaves and vacations; health practices; methods of handling discipline and grievances; separation by resignation or removal; retirement; service ratings; and living and working conditions. At no time should the employee or employer lose sight of the real purpose of the statement of personnel policies: that the aims and objectives of the organization shall be attained by the employment and retention of a competent staff whose basic needs and desires are satisfied through enjoyment of work and leisure both of which make their contribution to the ongoing activities and progress of human society.

Preview

Tuberculosis has been a factor in human destinies all through the world's history. Poet and peasant, rich man and poor, millions have died of this infection. With the strides that have been made in the early recognition of the disease, thousands are today receiving treatment who otherwise would have died. The early diagnosis of primary tuberculosis will be our feature next month. **Dr. G. F. Kincade** is Director of the Vancouver Unit of the Division of Tuberculosis Control. As another phase of the control problem, **Laura Coleman** will describe the use of B.C.G. as a prophylactic measure. **Mabel Sharpe** will discuss the role of the graduate nurse in tuberculosis sanatoria.

Infectious Mononucleosis

HELEN MORRISON

NURSES FIND THEMSELVES treating this disease much more often today then their colleagues did twenty years ago. Why? Because, until 1932, laboratory tests had not been discovered which would distinguish infectious mononucleosis from many similar conditions. As yet we do not know the cause of this disease, but the research worker, the doctor, the laboratory technician, and the nurse are all contributing to a growing understanding of its nature.

Infectious mononucleosis is an acute infectious disease, the etiologic agent causing it being unknown. It is characterized by an irregular fever, swelling of the lymph glands, sore throat, enlarged spleen, and blood changes which include an increase in the number of lymphocytes, and the presence of antibodies against sheep erythrocytes in more than normal titre.

The first description of the disease in medical literature occured in 1889. Through experimental study from 1918-20, changes in the blood count were first observed to accompany the general symptoms of what was commonly known as "glandular fever." In 1932, Paul and Bunnell discovered a test on blood serum which would distinguish the disease from similar conditions.

Susceptibility is apparently general as all ages are reported to have had the disease, but it is more common among children and young adults. The degree of immunity conferred by an attack has not been determined. The incubation period is thought to be four to fourteen days. Direct contact with an infected person is believed to be the usual mode of transmission. The importance of articles soiled with discharges of infected persons is not determined. The disease occurs sporadically and in epidemics. Though the degree of infectivity is not high, in institutions where people are in close contact a number of cases often occur at one time. It has been observed in many parts of the world and is probably much more prevalent and more widely distributed than the reported incidence would indicate.

CLINICAL PICTURE

The important thing to remember is the lack of a definite pattern. The signs and symptoms, while similar, vary with the individual:

1. *Onset* may be sudden or gradual and resembles the onset of many diseases. The most common complaints are fever, headache, sore throat, chills, swollen lymph glands, gastro-intestinal upset, and general malaise.

2. *Throat symptoms* are mild to typical follicular tonsillitis.

3. *Glandular symptoms:* The cervical, axillary and inguinal glands are most frequently involved. Most cases show glandular involvement early, but a few show none for two or three weeks. The glands are discrete, occasionally in clumps and are only moderately tender. They rarely suppurate.

4. *Spleen* is usually enlarged and may be palpated. It usually enlarges during the first week, and may persist for weeks or even months.

5. *Rash* does not occur in all cases, but a wide variety of rashes have been noted. The majority are morbilliform. Occasionally even a vesicular type may cause great discomfort.

6. *Jaundice* occurs in a small per cent of cases.

7. *Fever:* Rising to about 103° F., the fever usually falls to normal, by lysis, in two weeks. Mild cases have little fever.

8. *Relapses* are common and may occur several times carrying the disease on for weeks or months.

Eventually all symptoms disappear, and after a slow convalescence, the cure is complete.

Types of the disease: (1) Simple, glandular — most commonly found in children. (2) Febrile — usually seen in adults. The onset is sudden with general malaise, chills, and a temperature around 102°. The glands are usually enlarged. The fever falls to normal by lysis in about twelve days. A rash may be present. (3) The Anginose type is rarer. The common age is fifteen to twenty-five years. The symptoms of a mild attack of glandular fever may be present for a week or two. Then the constitutional symptoms and the sore throat become more severe. A membrane forms rapidly on the fauces. This is indistinguishable in appearance from diphtheria. Mental anxiety and discomfort are great. The temperature may be 104° for about two weeks. After several days the membrane separates. The convalescence is slow.

The blood count: Important in diagnosing infectious mononucleosis is the blood count and differential: (1) The red blood count and hemoglobin are unchanged. This helps distinguish the disease from lymphatic leukemia. (2) The white cell count is increased in most cases. There is usually a count of 10,000 to 20,000. A few go up to 40,000 and a few go down to 3,000. The white count seems to have no relation to the severity of the disease. It can only be used as one factor which gives an indication of the presence of infectious mononucleosis. (3) The differential count (smear) usually shows an increase in the number of lymphocytes. They increase to 60 or 80 per cent (sometimes 90 per cent) of the total. A normal count shows 25 to 35 per cent of lymphocytes.

Just why the cell-producing mechanism is changed is a question researchers are at present trying to answer.

The Paul Bunnell test: This test, discovered in 1932, is the most positive test we have to help diagnose infectious mononucleosis. It is based on the presence of sheep heterophile antibodies in the blood of the patient. Its importance lies in the fact that these antibodies are not increased in diseases which resemble infectious mononucleosis. A summary of the test is as follows:

(a) Take 11 test tubes; (b) add 0.5 cc. of physiologic saline to all but No. 1; (c) add inactivated patient's serum diluted as follows: (1) undiluted, (2) 1 in 2, (3) 1 in 4, (4) 1 in 8, (5) 1 in 16, etc.; (d) to each test tube add 0.5 cc. of 2 per cent suspension of sheep cells; (e) add 1 cc. saline; (f) incubate one hour and read the results; (g) read as follows: + + + cells remain in single clumps; + + clumps visible, but suspended; + agglutination seen only under a microscope; (h) significance — a positive reading for a ½ dilution is normal. Some factors can give a positive reading up to 1/64 and no disease is apparently present. Above 1/64 the Paul Bunnell is considered positive for infectious mononucleosis.

Patients who have had horse serum within a year may give a high reading. If such a history is present, special laboratory tests can eliminate the serum. Some cases have been observed with negative Paul Bunnell tests, and yet all the signs and symptoms of infectious mononucleosis were present.

Case History

Mr. H is a young man of twenty-three. He is a returned serviceman and a university student. When he presented himself to the doctor, he sat down with a deep sigh, and said, "I don't know what it is, but I surely feel as if I've had it." Two weeks before his roommate had reported off sick with similar complaints and was still in bed. Mr. H had been "off color" for a week, but had been loathe to report his illness due to the pressure of studies. However, this day his throat was so sore, and he felt so miserable, a university degree had lost its significance.

Signs and symptoms: (1) Several glands were enlarged, discrete but not tender. The sub-occipital and sub-mandibular were most involved. (2) The patient was subject to severe sore throats. A tonsillar abscess was present at this time. (3) There was a mild conjunctivitis. (4) Headache had been fairly severe for four days. (5) The spleen was definitely palpable. (6) A faint morbilliform rash was present on the hands. (7) Temperature 102°, pulse 96, resp. 22. (8) The patient complained of increasing lassitude and weari-

ness. (9) Laboratory tests were as follows:

Hgb. 85% 11.5 gm.
R. B. C. 4,600,000 } normal

W.B.C. 9,400 — slight increase.

Differential — polys. 34%; lymphs. 66%.

Paul Bunnell 1/256 + + + and 1/1024 +. An increase in heterophile antibodies greatly above normal.

The *treatment* ordered was the same as for all cases: rest in bed and symptomatic treatment.

Throat: Hot saline irrigations every three hours. External heat to the neck gave considerable relief. Massage with analgesic balm was comforting. Penicillin 20,000 units q.3h. was given for the throat condition. (It has no known effect on infectious mononucleosis.) The tonsillar abscess broke on the fourth day, with great relief to the patient.

Eyes: Warm boracic irrigations with an instillation of neo-silvol q.4h.

Epistaxis: The first week the patient had three severe nose-bleeds. A cotton plug soaked in adrenalin and external pressure controlled this.

Diet: High caloric fluids were forced the first week as the throat condition prevented him from taking solids. Later a high caloric diet, as desired, was given.

General nursing measures: Frequent sponge baths for excessive perspiration were given. Laxatives were necessary due to the lack of solid food and the listlessness.

Mental outlook: The most difficult nursing problem was the depressed outlook of the patient. Though a certain depression seems to accompany the disease, personal problems can make the worry retard the patient's progress.

Problem number one was financial. Here was a young man, spending his war gratuities getting an education. He had already missed two weeks through a previous illness. As the days slipped by, and he found he could not arouse the energy to study, he became very depressed and irritable on the subject. By arranging a consultation with the proper officials, who were able to give him advice regarding his gratuities and allowances for illness, the matter was quickly clarified. Mr. H decided to concentrate on recovery, and start his course over with the next class.

Problem number two was emotional. This young man was to be married shortly. He had always written his fiancee every day. Now he found he was too miserable to write at all. The young lady could not understand how a prospective bridegroom could be so listless. Her letters arrived but each one left the young man very upset, and without the energy to solve the problem. As we felt his peace of mind was necessary to help speed recovery, we welcomed his request that somebody write to her and explain how miserable he felt. Fortunately, she understood and wired a dozen roses! His interest in trying to eat and be cheerful soon increased. It was most encouraging to see the favorable effect the solution of personal problems had on the progress of this patient.

Progress: The throat condition was cleared up in ten days. Temperature returned to normal by lysis in fourteen days. The rash disappeared in three days. He was discharged after one month in hospital. The glands were still enlarged, as was the spleen. He had lost sixteen pounds in weight and still lacked energy. He was advised to take a long convalescence, including high caloric foods, vitamin capsules, plenty of sunshine, fresh air, and rest. The convalescence for this patient may be long, but his recovery will be complete, and there will be no permanent ill-effects.

False Emphasis

The control of communicable disease in schools is sometimes hampered by placing false emphasis on perfect or near-perfect attendance. Rather than by giving certificates or awards for such dubious distinction, commendation should be extended to pupils who protect the health of their classmates by remaining at home when they are not well. Allotment of State funds to schools on the basis of the average number of pupils in daily attendance is equally bad practice because it makes teachers anxious to force attendance on pupils who ought better be at home and in bed.

—*School Life*,
U.S. OFFICE OF EDUCATION

Caring for Flowers and Arranging them in Hospitals

SISTER NADEAU

WITH SO MANY serious problems confronting the hospitals nowadays, this subject may appear rather futile to outsiders and even to people whole-heartedly interested in vital questions pertaining to the nursing care of the sick. Yet, had not the topic its own objective importance, the word alone of the gentle Lover of men, "What thou dost to the least of my brethren, thou dost it to myself," would be sufficient to raise our considerations on the care of flowers in the hospital far above the level of mere trivialities.

Granted that flowers and the special language they speak are for the patient as essential a therapy as medicines and food, to whom should the care of flowers be confided?

In our specialized era with a place for everyone and everyone in his place, a logical answer to the question might well be, "Let the florist attend to this matter." But, with all due respect for evolution in the hospital field, one must admit, since human nature does not change, that the old procedure of treating the patient as a whole still holds good. No matter how many specialists approach them, whether they belong to the medical staff, social workers group, occupational therapy experts, ladies auxiliaries, etc., still the great majority of our patients, if not all, will appreciate no one better than "their nurse", she being to them the personification of service in its most complete aspect. Consequently, the various forms of assistance with which she can surround her patients are apt to be more beneficial than any consideration granted them by some other people who, being farther away from their immediate interests and needs, are also proportionately more distant from their hearts which, by the way, form part of "the whole." I can remember an old patient telling about the kindness of her nurse and illustrating her statement by this remark: "She even thinks of arranging my flowers for me in the morning and I never asked her to do it." Those little attentions produced gratitude, but one can easily picture the opposite reaction, of grief or discontent, on this particular lady seeing an aide coming in to do the job the nurse did not do for her or, worse still, the flowers not being attended to because some thoughtful florist has done the work ahead!

Flowers bring joy

And have you ever thought of what would happen if one day

The nurses all decided that they'd like to run away?

Of course, there is a lot to be said against the time spent by the nurse while arranging the flowers, especially when there is the shortage of personnel that all hospitals have experienced in the last few years. The author perfectly agrees that if some work has to be left undone, the patient rather than the flowers must be attended to, but she still believes that

in hospitals where the ideal aspect of nursing can be considered, the care of both patient and flowers must be left to the same nurse.

Furthermore, not only the patient but the nurse herself will benefit by it. Have you ever seen a bouquet simply jammed in a flower container? If you have any sense of beauty, has not the sight offended you and did you not feel like teaching a lesson to the person with no more esthetic taste? Well then, you will understand why I feel like making a few remarks in that line to the nurses who come to us for education. Here is opportunity for self-expression and development of personality. Why not give her the chance? She will enjoy it, if at first she is given some hints for a beautiful arrangement; just enough to let her, through her own initiative, make for herself pleasant discoveries. And what, if the half-hour work she will give to this agreeable task after the morning's rush, will take off the wearied look on her face and put on a blissful smile instead! Any experienced nurse will admit that flowers will do even that!

From the many things to learn about the care of flowers let us pick up a few principles based on the fact that flowers are intended for beauty and for the conveying of affectionate feelings on the part of those sending them. How to arrange flowers in a container, where to place them in a patient's room, and how to keep them as long as possible, are all problems that will be encountered by the nurse if she cares to give those flowers all the artistic value they possess.

Let us study first the arrangement of flowers in the vase. Here, as anywhere else, it is good to remember that unity is a synonym of harmony and simplicity the highest form of beauty. If cut flowers are to meet the standards of an outstanding arrangement they must approach as much as possible unity in color and simplicity in lines and form. Bouquets of just one color are the simplest to arrange and have this other advantage of being restful to the eye. If for some reason this cannot be done, white can be added; it blends well and is a good co-ordinator. Or take the different shades of the same color, placing the darkest shades near the lower part of the arrangement. Even if asked to make a bouquet out of a variety of flowers and colors, harmony must be sought and attained.

Do not forget to add green leaves: it is more like Nature's way of acting. Remember also that the leaves belonging to the same plant as the flowers are more suitable; at least, the nearer to what they are like the better.

The importance of the receptacle must not be minimized. A simple container with no adornment is preferable. We want to keep the attraction focused on the flowers. It must be so chosen that short-stemmed flowers will not be placed in long containers and vice versa. Moreover, the stems should not be all of the same length. If they are cut so as to provide different curves the gracefulness of the bouquet will certainly be greater.

After the patient has had time to admire the bouquet in the nurse's hands and enjoy its fragrance, where is she going to place it in the room? A thoughtful nurse will know without being told that it must be in the patient's sight. Flowers are a message of sympathy and love from some dear ones at home and we all know how often we like to read friendly messages. It might not be superfluous to recall how most flowers have their charm enhanced by being placed in the sunshine. Here again this rule admits exception and you might have to choose a humbler spot, from a low stool to right on the floor if the effect of the bouquet is best obtained by showing in its ensemble the whole bunch of flowers. Heat also is more than the flowers can stand, so beware of the radiators!

The bouquet being so beautifully arranged, we will all like to keep it as long as possible. This is not so

easily discussed and still less easily done. So many prescriptions have been issued that have never been entirely satisfactory. Personally, I believe in B-Complex, one tablet a day in each receptacle; this, of course, if the patient can afford it. Plenty of water, and vases with a base large enough to provide sufficient room for the stems will also be necessary.

But even if flowers are necessarily short-lived, we still have reasons to be thankful. For long after all the petals, one by one, have been scattered in the patient's room, the corridors, the utilities, flowers never really die, because as a poet wrote, "A thing of beauty is a joy forever."

Effects of Extreme Cold

Extreme or prolonged cold tends to clot red blood cells so that they plug the circulation, which eventually results in development of gangrene and loss of limbs. This has been established, both by careful study of pathological tissue from overseas soldiers, and experiments with rabbits in which limbs were subjected to temperatures of minus 30° centigrade.

The condition became of great importance during the last war. It was most dramatically exemplified among air crews subjected to the extreme temperatures four or five miles over the clouds. Exposure of even a minute or so might result in the loss of a finger.

It was one of the chief causes of casualties in the Apennines campaign of the winter of 1943-44. Infantrymen sometimes stayed days at a time in fox-holes filled with slush and ice-cold water. When they were relieved they would be unable to walk and were in almost unbearable pain. Often this persisted for weeks after treatment and loss of toes was not infrequent. The condition was one with which there had been little previous experience and its pathology was not understood.

A report on the samples of pathological tissue has been made. Several varying effects of cold were noted but in all cases were found the red blood cell "plugs" which had stopped the circulation and prevented its restoration. Hence part of a limb would lose its blood supply and gangrene would be the almost inevitable result. The same condition could be produced in the rabbit limbs immersed half an hour in alcohol at minus 30° centigrade. This was a far more severe exposure than a soldier ever would be likely to encounter. The clotting could be prevented in the rabbits, however, by injections of an anti-clotting substance, heparin. Treated rabbits seemed little the worse off when their legs were thawed. —*U.S. Public Health Service*

1946 Index

For the past two years, the Index of all material published in the *Journal* has been printed as a separate booklet. As soon as the copies were available, one was mailed to each subscriber. This year the Index will be printed separately but, in order to conserve paper, it will not be distributed to each name on the mailing list. Instead, special cards are being printed which will be found in the December issue. All that you will have to do in order to receive a copy of the Index will be to fill in your name and address and drop the card into the mail-box. We will pay the postage on these cards when we receive them. Copies of the Index will be available early in the New Year. They will be mailed, without cards being sent, to all hospitals, universities, and libraries on our mailing list. Individual subscribers are asked to forward the special card as quickly as possible so that we may have some estimate of the number of copies of the Index that should be ordered.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

Canadian Industry and Canadian Nurses

FRANCES C. HARRIS

THIS IS REALLY a report of the development of our Standing Committee rather than a resume of activities. Early this year I received a notification that the establishment of such a committee had been considered at an executive meeting of the Public Health Section of the Canadian Nurses' Association and that I had been appointed as chairman. The selection of members was left to me with the suggestion that each provincial Public Health Nursing Section might be asked to appoint an industrial nurse to work with the Committee, if it considered it advisable to do so. Some of you may be familiar with Thomas B. Reed's definition of "reform." He was an American statesman and he once spoke of reform in these terms:

An indefinable something is to be done,
In a way nobody knows how,
At a time nobody knows when,
That will accomplish, nobody knows what.

Quite frankly, that sentiment was my first reaction to this appointment— — but not for long — nobody wants that kind of reform, least of all, the nursing profession.

The first and the last thing that is dinned into our ears by our directors of public health nursing is always the same: "Be objective — you *must* be objective." The ultimate objective of nursing in industry is always —"The *health* of the worker." The nurse understands that industry is run for profit but she is not in industry for the sole benefit of management. Regardless of cost, the industrial nurse must have the courage to present management with facts about working conditions which are detrimental to health. It would seem that the first objective of this Committee should be:

To assist industry in providing an adequate health service, based on essential factors, and adjusted to patterns of local medical and nursing practice and existing community health facilities.

True, the whole responsibility for industrial health does not rest on the nursing profession. However, it is a fact that nurses constitute the largest group of professional workers rendering health and medical services to industry. The graduate registered nurse is the recognized key worker.

Many nurses do not seem to grasp that this field of nursing has developed without much guidance from our own professional group. Factory Acts make it incumbent on employers to provide trained first aid workers but there is little standardization of the service required or of the personnel responsible for giving that service. It has been left to the individual employer to interpret medical, nursing, or welfare service, according to his own ideas.

The policies of industry in providing health services have varied *widely*. A few firms have sponsored

broad constructive health programs which include intelligent placement of workers and guidance for those who should seek medical care for physical defects or accidents which make them unemployable. Some firms show a genuine interest within narrow limits in aiding employees with health and social problems, but the vision of many employers is limited and they engage nurses purely for self-protection or to reduce compensation costs.

Sometimes one feels that the term "industrial nurse" is ill-chosen. The nurse does not come from industry to us seeking membership in the nursing profession. She is one of us. She is a nurse in industry who has been called into this type of work by labor and its employers. It is sometimes very difficult for the individual nurse to sell her health program. Her success may depend greatly on her preparation and her ability but she cannot successfully carry on alone. She should have the support and guidance of the medical profession and of the nursing profession. There has been little concerted effort toward developing a supervisory group in the field of industrial nursing. It is admitted that supervision of nurses engaged by private organizations presents difficulties, but it has been accomplished to a certain degree in other fields of public health nursing.

I do not believe that the preparation of the nurse for industry should constitute a major problem. Nurses in industry are like nurses in any other field. Once they know that certain duties are theirs, they assume their responsibilities. They have tried and they will try to prepare themselves one way or another to fulfil their obligations to the people they serve. Dr. Alice Hamilton, a pioneer in the field of industrial medicine, said:

> I have met a number of industrial doctors who were devoted to the interests of their employers to the point of indifference to the welfare of the workers, but I have met only one industrial nurse of whom that could be said.

It is the second objective of this Committee to promote, through the Canadian Nurses' Association, sound policies and practices among nurses engaged in industry. Our universities have already taken this matter in hand and our hospital superintendents are also interested. It was encouraging to read in a recent issue of *The Canadian Nurse*, a short article suggesting ways by which industrial public health nursing might be integrated into the basic nursing curriculum. The student nurse can be taught to recognize the student health program as an industrial health program. The student nurse who cares for patients suffering from industrial accidents can be interested in the history of these injuries, compensation laws, and the cost of accidents to employees, management, and the community.

The third objective of our Committee is to provide opportunities whereby nurses already employed in industry may obtain post-graduate and refresher education, and educational material relating to the medical and health problems affecting workers. From all parts of Canada, nurses in industry send requests for this help and this material. Industrial nurses seek advice regarding personnel practices, salary schedules, nursing policies and approved methods of recording, etc. The basic problem before this Committee is not where or how can the nurse entering industry be educated. Our directors of nursing eduction can make that decision. The real problem facing the industrial nurse is the same old problem of every other public health nurse. Am I getting my message across to the right people and if I am not, how can I reach them? Many health problems in industry remain unsolved because of lack of authority to handle them. Unwise direction of minor executives is frequently responsible for bad practices in the medical department. What is the most effective way to approach management? All nurses in industry do not have direct access to top management.

There is a need to enlighten

management regarding the relationship of industrial nursing to other branches of nursing service. As far as the workers are concerned, individual counselling is still the most effective method in industrial nursing as in any other public health teaching. Health education in industry is a subject upon which there is much debate. Group education may be done through lectures, movies, pamphlets, posters. There is a difference of opinion about the time, place, and methods to be used. A plant cannot operate with workers away from their benches, but when management needs to be informed, the industrial nurse, the provincial consultant, and the federal consultant can do little individually.

A committee established within the Canadian Nurses' Association should have the support of the Industrial Hygiene Division of the Canadian Medical Association. However, it is essential that the licensed physician most closely identified with a plant give his support and assistance to the nurse or nurses employed by the plant. The support of medical societies is not sufficient to help the nurse win medical supervision. "The Standing Orders for Nurses", compiled by the Council on Industrial Health, are not intended as a blanket mandate for all industries. It is necessary that each physician take a leading part in bringing about the establishment of a policy of written standing orders for all plants with which he has any connection. No one set of orders can be considered applicable to all industries in all communities. We hope that our Committee can find practical ways and means to assist the plant physician and the nurse in industry to bring their message of health to workers and to management.

One of the direct approaches to management is through the Manufacturers' Association. It has been suggested that this Committee prepare material approved by the Canadian Medical Association and the Canadian Nurses' Association, so that information can be distributed.

Our Committee has the assistance of nurses who are keenly interested in this field of nursing. We have: Misses Helen McArthur, Trenna Hunter, Margaret Hart, Muriel Hunter, Sarah Wallace. Our Standing Committee members are: British Columbia — Mrs. L. Grundy; Alberta — Miss Edith Marstad; Saskatchewan — Miss Elizabeth Smith; Manitoba — Miss M. Hart, Miss de Brincat; Ontario — Miss Sarah Wallace, Miss Grace Ryde; Quebec — Miss Mabel Fraser; New Brunswick — Miss B. Seaman. The field is wide and the opportunities are great. It depends on the nursing profession itself how this service is developed.

Do They Practise What We Preach?

RAE CHITTICK

FOR TWENTY-FIVE YEARS we have been giving health instruction in our elementary schools. What effect has it actually had on the health of the nation? Do boys and girls really live more healthy lives because of it?

You begin to wonder what good the school health program does when you study the results of school health surveys and when you read the findings of medical boards which examined recruits for our armed services. These reports show that the number of physical defects in our young people is appallingly high. For example, about 80 per cent of children when they reach the age of leaving public school suffer from dental caries. And dental caries

isn't all! Infected nose and throat conditions, signs of malnutrition, poor posture, and defective eyesight — all seem to indicate that the health teaching given in the schools is not put to much use in the lives of the children who receive it.

For more than ten years, a careful record has been kept of the medical examinations given students who enter the Calgary Normal School. Only about 10 per cent of these students appear to be free from defects requiring medical care or advice. And this, we should bear in mind, is probably a superior group since all of them are high school graduates. Somewhere along the line, it appears, the health program has failed to meet the needs of these students.

The school health program has always been criticized on the grounds that it is too academic: too much theory and not enough practice. This criticism still holds true despite all the efforts on the part of teachers to bring it right into the everyday lives of the children. Almost any child in the elementary school today can tell you that he ought to drink four glasses of milk a day, that he should eat brown bread instead of white, and that he should be in bed at a certain time each night. The chances are that he will answer correctly practically any simple question regarding the rules of health. But have these rules any real meaning in his actual, everyday life? Isn't it true that he leaves them behind him when he runs down the school steps? What many of us have failed to realize is this — that the greatest influence in a child's life is his home. What he eats, what he drinks, and what he wears are almost completely determined by his parents.

Must we assume from this that we are wasting time by teaching health in the schools? Most authorities say no. What is needed, in their opinion, is a much closer co-operation between the home and the school. What the child learns about health in school could easily be put into practice if the parents insisted upon it. And just as the health program should really be lived in the home, so also it should really be lived in the school. In every way possible, the teacher should see that there are opportunities at school to do many of the things mentioned in the health program — from washing the hands after visiting the toilet to choosing a nutritious noon meal if the child stays for lunch at school.

There are many ways to improve the school health program — better trained teachers, better equipped schools, and more time for health education. But the greatest need remains: we must make sure that the teaching we give at school is put into actual practice in the home. Parents must know what is best in health teaching and must have the sense of fortitude to carry it out.

How can we change the attitude of parents or their ways at home? Education seems to be the answer but it is a slow process. The classic example of this is the effort made by the government during the war to promote the consumption of Canada Approved flour and Canada Approved bread. It was repeatedly brought to the attention of every housewife by the press, periodicals, special workers, and the radio. But after four years of vigorous advertising it was found that only about 10 per cent of the flour being sold was Canada Approved. Now that the war is over there is practically no demand for it. The need for vitamin B, it appears, vanished with the need for patriotism.

How can we change people's health practices as a whole if we can't even change their choice of food? One of the guest speakers at the 1946 Canadian Medical Association convention, held in Banff, was Dr. Donald Paterson of the Hospital for Sick Children. He told the meeting that he would like to see food rationing continued "indefinitely" in post-war Britain. The British people, he explained, were much healthier as a result of food rationing, particularly the poor. However, our whole ex-

perience in the English-speaking world suggests that compulsion and regimentation do not produce satisfactory results. Sir Wilson Jameson, Chief Medical Officer for England, takes up this point in the May, 1946, issue of the *Canadian Journal of Public Health*. He says that the compulsory vaccination of infants is to be abolished since it has never been a success. "It is generally believed," he says, "that the removal of the element of compulsion from vaccination will have the effect of inducing larger numbers of parents to have their children vaccinated."

If then we set aside the idea of compulsion, how can we promote *voluntary* health action in the home? The obvious answer to this question is the public health nurse, who serves as liaison officer between the home and the school. She knows the school health program and she knows something of the child's life at home. She, more than anyone else, can interpret the school health program to the parents. Furthermore, she can help the teacher to understand a child by interpreting to her that child's home background.

The public health nurse is well aware of the important role she plays. Yet there is still room for her to play this role more successfully. The public health nurse working with school children is not familiar enough with the curriculum nor is she in close contact with what the teacher is doing in the classroom. Since the work in health should be based on the children's needs, the school nurse should sit down and map out with the teacher the kind of lessons which would be most helpful to the class. She should also be able to suggest references and sources of material for teacher and child alike.

In present-day education, health teaching is integrated into many phases of the school program and plays an important part in classroom projects and enterprises. Too often, however, the teacher misses valuable opportunities for health teaching in developing a project because she is not aware of the possibilities. This is where the school nurse can help. By following the activities planned in a class enterprise she can show the teacher many ways in which health lessons may be introduced as a fundamental part of the project.

The school nurse is a busy person but she should never be too busy to go into a classroom and observe children at their work and listen in on their activities. By so doing she can learn a lot about the kind of work the children are doing, the surroundings and atmosphere in which they are working, and their general reaction to the whole school set-up. What better way could there be for the nurse to become familiar with the school program and thus be able to assist the teacher with her health instruction?

This isn't the only advantage the school nurse can gain by visiting classrooms during the day. Nurses are inclined to concern themselves chiefly with physical health; they are so anxious to find and correct physical defects that they miss many signs of poor mental or emotional health. The nurse who sees a child only in a medical examination room, or looks at him for a short time while she makes a routine inspection, has no opportunity to observe his reactions towards his teacher and his classmates. The nurse who helps conduct lessons or takes part in a class activity will soon discover the diffident, shy child, the aggressive, boisterous child, the over-talkative child, the child who makes a tremendous bid for attention, and the child who is unhappy and withdrawn.

All authorities agree that the behavior of a child in school reflects the atmosphere of his home and the kind of treatment he gets there. Thus the school nurse, by studying the child's behavior in school, can estimate the influence of his home environment. Through this knowledge she can help the teacher to a better relationship with the child. She can also help the parents. By observing the behavior of a child in the classroom she can suggest to the parents ways and means by which the young-

ster can be assisted or improved.

There is another important way in which the school nurse can do a better job—she should be more careful to explain the exact nature of defects and illnesses to a teacher. Many teachers, for example, do not know the real significance of rheumatic fever and the related diseases of growing pains and chorea. Many do not know what precautions to take to prevent infection from spreading in the school. A good many teachers still harbor the idea that a classroom should be closed and fumigated after some communicable disease has broken out among children in the class. When the physical examination of the children in a classroom has been completed the school nurse should make sure that the teacher understands the health status of each child, and what kind of help any particular child should be given.

One of the best means of checking on the child's health, both physical and mental, is by noting the amount of time he misses from school. Absenteeism tells us a good deal about physical illness; it also tells us whether or not the child likes school, his attitude towards his teacher, the stresses and strains of his home life, and many other important factors. It is essential that the teacher and school nurse work together to understand and control the absences of a child from school. This subject is considered so important that the Canada and Newfoundland Education Association and the Canadian Public Health Association are jointly sponsoring a very careful study during 1946-47 of the reasons why children fail to attend school.

To sum up, then, here are six ways in which the school nurse can help to improve the health program and make it really work in the lives of children:

1. Interpret the school health program to the parents. This does not mean just what is being done by way of medical examinations, dental inspections, or inoculations, but also what is being done in the classroom by the teacher and pupils working together. To do this effectively the nurse must know the curriculum and something of modern principles of teaching.

2. Help the teacher plan her health program in the light of the program of studies and the children's needs. Give her suggestions as to source material and stimulate her to become better informed and more enthusiastic about health work in her school.

3. Spend some time in the classroom to discover what the children are studying and how they go about their work. This should not be done as an observer but as a helper and participant. Use every opportunity to get into the classroom and work with the children. This is the best means of learning how to help the teacher and of discovering the mental and emotional health of the children.

4. Try to give the teacher some insight into a child's behavior in the light of his home environment. Work out a plan with the teacher to adjust the child in the light of this knowledge.

5. Make sure the teacher understands the nature of the physical defects from which her pupils may be suffering. Keep her informed on new trends in promoting health and controlling disease.

6. With the help of the teacher make a careful study of absences of children from school and make this study useful in improving the child's mental and physical health.

Vitamin C in Market Vegetables

Packing vegetables in crushed ice as they are harvested is an effective way to prevent deterioration during transportation and storage. The common practice of sprinkling vegetables to keep them fresh in retail markets was found to be of little help in saving vitamin C. Moisture without refrigeration is of no benefit. Tests show that mechanically refrigerated, iced or crushed ice display cases are all satisfactory for keeping green vegetables.

— *U.S.D.A. Food and Home Notes*

Contributed by Hospital and School of Nursing Section of the C. N. A.

Instructors' Workshop

GRACE SPICE

SINCE 1941, in Manitoba, students in schools of nursing have been writing Qualifying Examinations within the first year of attendance in the school. These examinations test the students' progress in subjects usually covered in the preliminary term in schools of nursing — Human Anatomy and Physiology, Nursing Arts, Microbiology, Nutrition, and the mathematics of Drugs and Solutions.

Early in 1946, the Board of Managers of the M.A.R.N. decided that with four years' experience and examination results to work over, it would be advisable to "review the policy of the Association regarding Qualifying Examinations" and forthwith called a meeting of the people most interested—the superintendents and instructors in all the schools of nursing in the province. Out of this meeting, which heartily endorsed the policy of the Association in conducting Qualifying Examinations and recommended that they be continued, also came the recommendation that the course outlines that were set up by an Instructors' Institute in June, 1943, for the preliminary courses tested in the Qualifying Examinations be reviewed in the light of the years of experience. So, during the week of June 17, all six working days of it, the instructors in schools of nursing in Manitoba gathered in Winnipeg for a Workshop to do just that and also something that had not been done before — to set up course outlines for the courses tested in the Registration Examinations in Manitoba.

The Workshop was under the able direction of Miss Anne Carpenter, science instructor at the Winnipeg General Hospital School of Nursing. Miss Hazel Keeler, director of the School of Nursing Education, University of Manitoba, attended the opening session and in a very practical way reviewed for the participants the mechanics of preparing course outlines based on the philosophy underlying present day educational methods. The participants represented most of the schools of nursing in the province and came from both the classroom and the clinical fields. After the first day there was a stenographer on hand to type the work done on each course by the instructors interested in it so that their work could be presented to the group as a whole for discussion.

The instructors, who were primarily interested in the Qualifying subjects, were about nine in number and they divided themselves into two groups — one to work consecutively on the science subjects, Anatomy and Physiology, Microbiology, and Drugs and Solutions, and the other to work on Nursing Arts. The course in Nutrition, as set up previously, was considered by those teaching and examining in it to need no revision.

The discussion of the Qualifying

course outlines was very practical. Much of it was along the lines of the following excerpts:

I know it makes the introduction to Anatomy and Physiology, which is rather theoretical, seem long drawn out if you teach the Connective and Epithelial Tissues in the first unit, but that is where I do it.

How many of the alternative names for any one organism do you think we should hold the students for? I think the Qualifying Examiners should stick to the nomenclature used in the course outline and that would give the teachers something to go on.

I don't think we can expect students to remember the concentration of solutions and the time of exposure for disinfectants that they never use. There is such variety in them these days that one that may be in constant use in one hospital may not even be stocked in another. I think we should include a minimum list of disinfectants for examination purposes in either the course outline for Microbiology or Nursing Arts.

In general the course outlines for the qualifying subjects remain very much as they were before the Workshop. Some deletions were made of topics nobody "had time to teach" anyway. Some clarifications were made of points that instructors had found ambiguous in the first drafts. In a few cases subdivisions were made into "obligatory and optional" subject matter.

For the instructors who had taught from the original outlines, the values of the Workshop were largely those gained from free discussion of topics of mutual interest and the sharing of experiences both profitable and unprofitable. Besides course content, they also discussed hours of class and hours of laboratory and supervised practice, various textbooks in all the courses, the questions on recent Qualifying Examination papers, the correlation of courses to avoid repetition and yet ensure the highest degree of learning, and many other related subjects.

The instructors and clinical supervisors who were interested in the subjects in which the students are examined in Registration Examinations had to work from scratch. In Manitoba, the students write the following Registration Examinations:

Medical Nursing, Surgical Nursing, Obstetrical Nursing, Pediatric Nursing, Diet in Disease, Communicable Disease Nursing and Community Health, Surgical Specialties (gynecological nursing, orthopedic nursing, eye, ear, nose and throat nursing).

The course outlines were set up for these courses as were those for the Qualifying subjects with broad objectives for the whole course stated first, then the course divided into units and the objectives and course content worked out in detail for each unit.

One of the advantages of working in a Workshop was that on the last two days of the week each group that had concentrated on an individual course presented its work for the consideration of the whole group. In this way some errors and omissions were picked up and every instructor present, no matter what her specialty, was exposed to a large mass of the subject matter that students are required to master in a three-year course. More than one instructor commented that in no other way than by "training over again" could she have got so adequately up-to-date on what is being taught in schools of nursing in Manitoba at the present time.

Some subjects which are taught did not come under consideration at all of course, for example, the appreciation courses like History of Nursing, Ethics of Nursing, Professional Adjustment, which are not examination subjects and some others like Tuberculosis Nursing, Dermatological Nursing, Venereal Disease Nursing, Psychiatric Nursing, Pharmacology, which the students are warned will be touched on in one paper or another.

The Board of the M.A.R.N. has recommended that such a Workshop be an annual event and the instructors present were all in favor of the suggestion. In fact, after spending a week discussing course content for examination subjects, the group as a whole agreed that another good topic for a Workshop would be "Examinations!"

So that may be what Manitoba instructors are bothering their heads about in June of 1947.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

L'Orientation Nouvelle de l'Infirmière Hygiéniste

BRIGITTE LALIBERTÉ, B. Sc.

DEPUIS LE DEBUT des jours sombres de la guerre et surtout depuis la fin des hostilités, les éducateurs, les associations professionnelles, les directeurs de personnel, tous parlent d'orientation. Orientation des démobilisés, hommes et femmes, orientation de la jeunesse et ré-orientation des travailleurs de l'industrie. En plus, "sécurité et orientation" sont également les mots d'ordre des nombreuses organisations chargées d'étudier et de résoudre tous les problèmes de l'heure.

Pourquoi est-on devenu si soucieux du bien-être de chacun, si ce n'est en vue d'aider chaque individu à retrouver dans la vie normale, la place qu'il peut occuper de la manière la plus profitable pour lui-même et la société?

Puisqu'ici, les problèmes qui nous intéressent sont ceux qui concernent l'infirmière-hygiéniste et que cette dernière a une place bien déterminée dans l'équilibre social, il est tout naturel que nos associations professionnelles et particulièrement les services d'hygiène lui accordent une attention bien marquée.

Avant de faire mention des méthodes d'orientation propres au travail de l'infirmière-hygiéniste, il est très important que l'on considère certains facteurs qui l'aideront à accepter les directives offertes et lui assureront, à elle aussi, la sécurité matérielle et morale à laquelle elle a droit — salaire, vacances, congés de maladie et de convalescence doivent être proportionnés au travail ardu qu'elle accomplit. Peut-on s'attendre à ce que l'infirmière se rende allègrement à son travail chaque matin si son esprit est préoccupé par des soucis d'ordre pécuniaire? Est-il étonnant que parfois elle manifeste peu d'enthousiasme à la moindre demande de travail supplémentaire, lorsqu'elle songe qu'on lui demande beaucoup et qu'en retour on lui donne peu? Dans bien des cas, elle reçoit beaucoup moins que d'autres catégories d'employés qui n'ont pas eu à se soumettre à un entraînement aussi long et aussi rigoureux.

Pour ce qui est de sa sécurité morale, elle doit avoir l'assurance qu'elle est appréciée à sa juste valeur, que son entourage a confiance en elle et est prêt à l'appuyer en tout temps. De plus, le service qui l'emploie doit lui fournir des conditions propices à son travail et lui garantir la stabilité.

Les reproches formulés à l'endroit de l'infirmière hygiéniste sont nombreux. Pour un, on lui reproche de ne pas aimer l'étude. Si nous voulons être justes, nous admettrons que dans le passé, les facilités de parfaire des études en hygiène publique n'étaient pas très favorables et surtout que le coût en était passablement élevé. De plus, dans certaines organisations, on a semblé se désintéresser totalement de la préparation que l'infirmière devait posséder pour être admise dans un service d'hygiène publique. On a malheureusement ignoré, ou semblé

ignorer que chaque situation dans le domaine du nursing exigeait des qualifications spécifiques en rapport avec le poste occupé par l'infirmière. Si les situations idéales semblent bien irréalisables, nous avons, cependant, raison d'espérer que la situation tend à changer et qu'elle changera encore davantage dans l'avenir. Le tableau n'est pas aussi noir que certains pessimistes le voient, non plus est-il aussi beau que les grands optimistes l'imaginent? Un fait reste vrai cependant. Que les projets d'assurance-santé deviennent une réalité ou non, nos services de santé vont continuer de se développer et, afin de ne pas rétrograder, il nous faudra des infirmières qualifiées, prêtes à assumer la responsabilité de la direction de groupes d'infirmières.

On admet que dans le département de l'Instruction publique, les industries, les grands magasins, il faut des subdivisions et qu'il est inadmissible que les directeurs aient à s'occuper de tous et de chacun en particulier, des plus minimes détails du travail et des moindres besoins. Les services de santé ne forment pas classes à part: là aussi des intermédiaires ou agents de liaison sont essentiels. En ce qui regarde le travail des médecins et des infirmières, nous savons tous que la plus étroite collaboration existe ou du moins doit exister. Les officiers médicaux ou médecins hygiénistes accepteraient d'assez mauvaise grâce, et non sans raison, de recevoir d'un membre d'une autre profession, des ordres ou des instructions concernant leur travail. La raison en serait simple et logique. En ce qui touche à la pratique de la médecine, aux questions d'épidémiologie ou autres responsabilités de ce genre, l'infirmière ne tentera jamais de supplanter le médecin: elle est et restera toujours son auxiliaire. Cependant, lorsqu'il s'agit des pratiques et techniques du nursing, l'infirmière reçoit des ordres concernant le travail qu'elle doit exécuter, des ordres dictés avec les meilleures intentions, mais parfois difficiles à accepter; la raison en est simple; l'officier médical (ou le médecin hygiéniste) n'a pas eu, ou du moins a eu très peu de formation dans le domaine du nursing en hygiène publique. Qui, mieux qu'une infirmière, peut évaluer la préparation, la qualité du travail et les besoins d'une infirmière? Il va sans dire que l'infirmière appelée à diriger un groupe doit d'abord posséder en plus des qualifications scientifiques nécessaires, un jugement sûr, une personnalité agréable et surtout l'art de diriger. S'il y a des méthodes standards de travail, l'orientation de l'infirmière hygiéniste se fera progressivement et de façon continue par l'infirmière surveillante ou chef de groupe, selon qu'on veuille l'appeler. Comme dans le domaine de la psychologie, il n'y a pas de règles fixes et bien définies, chaque cas a ses particularités. Les modes d'approche seront influencés par le caractère, la personnalité, l'âge et la préparation de l'infirmière.

Avant l'énumération des qualités requises de l'infirmière-surveillante sur qui reposent tant de responsabilités, il serait opportun d'étudier les raisons qui justifient l'attitude hostile envers la surveillance rencontrée, parfois, chez les infirmières et voire même chez certains médecins. Deux de ces raisons que nous pouvons nous permettre de citer comme étant peut-être les plus importantes sont, la première, qu'une expérience désastreuse due ni à la mauvaise volonté, ni à la malice, mais bien au manque de préparation de la personne préposée à la surveillance, ait contribué à donner l'impression que l'infirmière surveillante avait pour devoir de toujours chercher la bête noire, bref, que son travail consistait simplement à découvrir et à souligner les erreurs. La deuxième raison qui peut expliquer cette attitude est le fait que l'on ignore entièrement le véritable but de la surveillance. On ne sait trop au juste de quoi il s'agit et la crainte de l'inconnu, qui est une réaction psychologique normale, fait que nous repoussons comme étant peut-être néfaste ou dangereuse toute innovation. Nous associons bien souvent avec le mot "surveillance" les souvenirs peu agréables de notre enfance, où une surveillante de récréations mettait un frein à nos jeunes en-

thousiasmes et à nos jeux trop bruyants. Surveillance, en hygiène publique aussi bien que dans les autres domaines, n'est pas synonyme d'espionnage. Bien au contraire, surveillance veut dire orientation, développement chez l'individu de l'autocritique, lui permettant de capitaliser sur ses talents et aptitudes, d'amender et de corriger ses imperfections, qui souvent, à son insu, l'empêchent d'évoluer et de faire progresser le service qui l'emploie.

Il va sans dire qu'avant d'arriver au poste de surveillante, l'infirmière doit avoir subi un entraînement. Celui-ci ne peut être laissé au petit bonheur. Le tort que l'on peut faire à la personnalité des infirmières surveillées ne se répare que bien difficilement; souvent, il est irréparable. Nous connaissons tous ce vieil adage: "Vous pouvez ruiner un homme, lui enlever son bien, détruire sa propriété, et quand même être pardonné, mais si vous détruisez chez lui la confiance qu'il avait en lui-même, vous avez détruit ce qu'il avait de plus précieux, ce qui lui permettait de faire face à la vie et de marcher la tête haute parmi le reste des hommes." Une fois réconciliés avec l'idée de la surveillance, les services demanderont à notre future surveillante d'être entraînée, soit en faisant un stage dans une organisation qui offre à son personnel cette surveillance démocratique que nous désirons ou encore ayant fait partie du personnel d'une telle organisation. Là, elle aura appris à s'évaluer elle-même. Elle saura les degrés variés de ses forces et ses faiblesses. Elle aura été encouragée à suivre des cours pour combler ses déficiences culturelles. En étudiant la psychologie générale et la psychologie appliquée, elle aura appris à comprendre et à interpréter le pourquoi de certaines réactions bien caractéristiques de chaque tempérament et surtout les méthodes d'approche à employer en travaillant avec un groupe. Autrefois, la théorie voulait que l'on naisse avec des aptitudes toutes spéciales et, qu'en dehors de ces aptitudes, il n'y avait rien à oser ni à espérer . . . on naissait voyageur de commerce, on ne le devenait pas. Nous nous sommes éloignés de cette fausse théorie. L'expérience a démontré que tout en gardant certaines variantes, l'individu est susceptible d'apprendre, moyennant qu'en plus de posséder les qualités intellectuelles lui permettant d'entreprendre des études de ce genre et de les mener à bonne fin, il reçoive son entraînement sous la direction de maîtres compétents et expérimentés. Quelle attitude notre infirmière-surveillante aura-t-elle après un tel entraînement? Elle aura appris qu'elle doit être premièrement, une hôtesse pour son groupe, un maître de cérémonie, un arbitre quand il s'agit de discussions à régler ou de problèmes à résoudre; qu'elle doit stimuler et guider, qu'elle doit être avant tout une éducatrice. Elle saura qu'afin de servir son groupe d'une manière éclairée et efficace, elle devra être capable de prendre une vue d'ensemble, être sensible aux moindres nuances, maintenir une attitude optimiste et impartiale, savoir approcher les problèmes d'une manière constructive et donner toujours l'impression qu'une solution est possible. Naturelle et sans affectation, elle devra être hospitalière envers toutes les idées et envers tout le monde, être honnête avec elle-même aussi bien qu'avec les autres, être en mesure de se sentir assez indépendante et dégagée pour voir les problèmes d'une manière impersonnelle. Sans préjugés, elle devra être aimable et posséder de l'humeur, ce qui n'est en somme qu'une combinaison de l'intelligence et de la sagesse. A ce point plusieurs penseront: fumisterie que tout celà! Nous connaissons des infirmières surveillantes qui n'ont pas eu tout cet entraînement et qui n'en possèdent pas moins un grand doigté. Soit! Plusieurs de nos grandes figures passées et présentes dans le domaine du nursing ont obtenu leur entraînement par leur expérience. Nous reconnaissons toutes le magnifique travail qu'elles ont accompli et accomplissent encore. Ce sont précisément elles, nos pionnières, qui ont aidé à tracer les directives que l'on enseigne aujourd'hui dans les universités. Nous leur sommes redevables des immenses progrès ac-

complis dans le domaine du nursing en hygiène publique.

Cependant avec la rapidité de la vie aujourd'hui et les besoins pressants et complexes de l'heure, et avec tous les développements que nos services d'hygiène entrevoient, nous ne saurions attendre ni espérer que la chance seule nous favorisera.

Pour bien faire le travail que l'on réclame d'elles, l'infirmière esseulée dans la campagne et celle qui fait partie d'un grand service urbain ont besoin toutes deux de sentir qu'il y a dans leur entourage immédiat quelqu'un qui les comprend, est prêt à les aider de ses conseils et sur qui elles peuvent compter en tout temps.

Si dès son entrée dans un service d'hygiène publique, on a bien expliqué à l'infirmière ce que l'on attend d'elle et le but de la surveillance, elle ne verra pas la surveillante comme une ennemie qui guette une fausse manoeuvre mais bien comme une amie qui s'intéresse à elle, l'accepte avec toute sa préparation (ou son manque de préparation selon le cas) et qui en tout temps respectera son individualité et l'aidera à évoluer.

Avant d'énumérer les méthodes de surveillance propices à l'orientation de l'infirmière, soulignons quelques facteurs qui influencent la nouvelle infirmière dès son entrée dans un service.

D'abord l'accueil avec lequel on la reçoit la première fois qu'elle se présente pour solliciter une situation, ou encore la première fois qu'elle se rapporte au travail. De cette entrevue dépendront fréquemment son attitude et la ligne de conduite qu'elle jugera bon de suivre plus tard. Trop souvent, hélas, lés besoins pressants empêchent le directeur ou la surveillante qui la reçoit de créer chez-elle le sens de la sécurité qui est le plus important facteur. C'est là la pierre d'achoppement la plus fréquente: on manque d'établir cette entente mutuelle et d'expliquer les pourquoi aussi bien que les comment du travail qu'elle aura à faire.

Des plans bien définis doivent être élaborés. Il est impérieux que l'on se rende compte, dès le début, des points forts et des points faibles de la nouvelle arrivante. On y parviendra en ayant des tests préparés par des personnes spécialement entraînées dans cette science; ces épreuves la mettront en face de problèmes qu'elle rencontrera dans son travail quotidien. Les questions seront posées de façon à se rendre compte si elle possède les connaissances et le jugement nécessaire: bref, elle sait ce qu'elle aura à faire ou elle ne le sait pas.

En se basant sur le résultat de ces épreuves, l'infirmière surveillante pourra déterminer la fréquence des visites de surveillance et le programme d'études à instituer pour prévenir les erreurs possibles et éviter des situations embarrassantes entre la nouvelle infirmière et les médecins du service, ou d'autres membres de la profession médicale, plaçant ainsi les autorités dans des situations équivoques et ennuyeuses. De cette façon, le maintien des standards professionnels et ceux du service sera sauvegardé.

La période d'orientation sera plus longue ou plus courte, selon les différents besoins. La surveillante repassera avec l'infirmière, les points jugés faibles à l'examen et immédiatement l'on décidera de la fréquence des visites de surveillance. Ces visites peuvent être hebdomadaires, mensuelles ou même, dans les cas les plus exceptionnels elles peuvent être annuelles seulement. De cette façon, l'infirmière surveillante préparera son programme de manière à ce qu'il lui reste du temps libre et elle sera en mesure de prêter main forte dans les cas imprévus.

L'infirmière sera toujours avertie à l'avance du jour et de l'heure où la surveillante se propose de l'accompagner dans ses visites, soit à domicile, à l'école ou à la clinique. Ce faisant, l'infirmière aura le temps de penser aux problèmes qu'elle veut soumettre à sa surveillante; elle réservera de préférence une visite où elle a besoin d'assistance ou, encore, une autre où elle veut avoir la satisfaction de montrer le bon travail accompli depuis la dernière visite de la surveillante. Elle aura également, qu'après chaque visite de surveillance,

un rapport narratif sera rédigé donnant un compte-rendu du travail exécuté en présence de la surveillante. L'attitude de la famille, des directeurs d'écoles ou instituteurs sera décrite et les questions et réponses reproduites textuellement.

Le rapport de la surveillante doit être rédigé immédiatement après la visite, à moins que des facteurs émotifs entrent en cause. Alors, il vaut mieux attendre quelques jours, la surveillante aura retrouvé son objectivité, pesé le pour et le contre et sera en mesure, lors de la conférence d'offrir des critiques constructives; de cette façon, l'entrevue avec la surveillante, au lieu de laisser l'infirmière dans un état de découragement et d'insécurité, la stimulera à mieux faire.

Ce rapport servira, non seulement à l'infirmière surveillée mais servira également aux autorités pour apprécier le travail de la surveillante. Les éloges et les reproches devront être basés sur des faits. Plus tard, lorsqu'il sera question de promotion ou de recommendation, un regard sur les rapports de la surveillante et sur les remarques de l'infirmière ajoutées au bas de son propre rapport serviront de guide dans l'évaluation du travail de la surveillante aussi bien que celui de l'infirmière surveillée.

La conférence doit avoir lieu privément et lorque l'infirmière est reposée, de préférence le matin. Le temps nécessaire doit être alloué et les interruptions évitées. La conférence offre à la surveillante l'occasion d'analyser sa contribution envers son département et son groupe. A-t-elle fait des progrès elle-même? Continue-t-elle à étudier? Est-elle au courant des nouveaux développements dans le domaine du nursing et de la médecine? A-t-elle contribué à l'avancement et aux progrès de l'infirmière qu'elle a surveillée la veille? Qu'a-t-elle à lui offrir comme directive si son travail est très bien fait? Si la surveillante compte qu'il n'y a ancun progrès depuis des mois, elle peut fort bien se demander si elle-même n'a pas manqué d'habileté. Comprend-elle bien tous les facteurs psychologiques qui entrent en cause et influencent cette attitude apathique? L'infirmière est-elle toujours sur la défensive? Montre-t-elle des signes d'inhibition ou est-elle tout simplement réticente? Par contre, est-elle brusque, impulsive? Pourquoi? L'infirmière se sent-elle assez en sécurité avec sa surveillante pour risquer de lui dire que ses remarques ne sont pas justifiées? La surveillante possède-t-elle l'art d'écouter sans interrompre? C'est pourtant un art à cultiver. La conférence entre surveillante et surveillée est considérée comme une des méthodes les plus désirables et effectives dans la surveillance. Elle donne un aperçu sur l'attitude que l'infirmière a envers son travail et le département qui l'emploie, sur ses problèmes personnels et sur sa philosophie.

L'infirmière doit être encouragée à évaluer son propre travail. Si la surveillante semble s'apercevoir qu'elle n'est pas heureuse, ou que certaines questions ne semblent pas réglées à la satisfaction des deux intéressées, elle doit encourager l'infirmière à voir les autorités supérieures. Occasionnellement, il est désirable de lui laisser écrire un rapport de son travail. Ceci requiert beaucoup de temps, mais par contre, offre une opportunité très précieuse de la réconcilier d'abord avec la surveillance et ensuite de l'entraîner à rédiger de tels rapports lorsque plus tard on lui confiera les stagiaires. Cette question des stagiaires, de si grande importance, ne pourrait être traitée dans les vingt minutes qui m'ont été allouées. Rappelons-nous, cependant, que les services d'hygiène bien organisés, offrent un champ d'expérience très riche et qu'aucune théorie ne saurait remplacer cette expérience.

Si nous constatons après un certain temps que l'infirmière possède les qualités potentielles requises pour devenir surveillante, qu'on ne craigne pas de le lui dire et de l'encourager à l'étude. Si elle a beaucoup d'ambition mais n'a malheureusement pas les aptitudes voulues, elle sera amenée à accepter sans amertume le fait que, pour son bonheur et sa sécurité personnelle et surtout ceux des autres, les nombreuses qualités qu'elle pos-

sède pourront être utilisées avec beaucoup plus de profit dans le service général, et que les vains efforts qu'elle aurait à faire pour vaincre une personnalité trop faible, ou à corriger un trait de son caractère indécis ou par trop rebelle, créeraient à la longue une telle tension, que des conflits psychologiques les plus variés et bizarres ne manqueraient pas de se manifester.

L'orientation de l'infirmière d'un service dépend de l'infirmière surveillante. L'infirmière surveillante, à son tour, est guidée et orientée par l'infirmière en chef, ou directrice des services d'infirmières. Comme le plus humble des travailleurs, l'infirmière hygiéniste a le droit d'exiger du service qui l'emploie, l'aide nécessaire afin qu'elle puisse s'acquitter de sa tâche de la manière la plus profitable pour elle-même et pour la société.

Preview

Any operation on the brain or its tissues is always of special interest. Neurosurgery, which was comparatively unknown fifty years ago, calls for highly specialized skills on the part of the nurses. You will enjoy reading the excellent description of prefrontal lobotomy prepared for us by **Elizabeth K. McCann** of Vancouver.

Assignment Sheet

MADELEINE FLANDER

THE ACCOMPANYING DIAGRAM is a section of an assignment sheet which has proven very satisfactory in an affiliating school where approximately one-third of the students on each ward change each week and where one-third of the total student body is replaced each month. The full size measures 25 inches square and is printed on good grade paper in blue and red — the division and vertical lines are red. (The blue lines do not show the diagram.)

It is filled out by the head nurse and the teaching supervisor. Usually the supervisor assigns the patients, the ward duties, and the relief. The head nurse assigns the hours of duty, the hours for norning diet, lunch, and dinner. The figures under these designating letters indicate first or second sitting.

The week begins on Tuesday morning and each student will know her hours for the ensuing week. As the patients change, the old names are crossed off and the new names inserted. It is true that this part of the sheet is untidy by the end of the week but that is considered of minor importance.

Each student is responsible for writing in each day the duties and special nursing or other orders which she wishes her relief nurse to perform. This is of value as it means that she will think back, look ahead, and review the day for each of her patients. It also lessens the possibility of mistakes.

The sheet is particularly useful to the head nurse and the teaching supervisor in that it is possible to see at a glance who is responsible for any one patient, who is responsible for any one of a number of ward duties, who is on duty ond who is off and who is relieving who. It also means that once the work has been completed on Tuesday morning, there will be very little time spent in assigning patients and duties during the remainder of the week. The classroom instructor finds that it is a great help to her in her rounds of teaching and supervision.

Name	Day	On Duty	Class	D	L	D	Patients	Diagnosis	Ward Duties	Relief — Tuesday	Relief — Wednesday
Miss C.	TUES.	7-3:30	10	2	1	–	Giselle M.	Celiac Disease	Fluids at 10 a.m. and 3 p.m.	Miss H.	Miss H.
	WED.	7-3:30		1	1	–	Michael N.	Eczema.		6 p.m. medications.	6 p.m. medications.
	THUR.	6-3		2	2	–	Edward B.	Hemophilia.		Routine care.	Routine care.
	FRI.	Day				–	James H.	Pneumonia.	Fruit 2 p.m.	Special care to Edward back	Edward — special back care.
	SAT.	7-3:30		2	2	–				Thank you	E. C.
	SUN.	7-3:30		–	1					E. C.	
	MON.	7-3:30		1	1	–					
Miss LaB.	TUES.	6-3		2	2	–	Dianne G.	Anemia.	Care of Thermometers.	Miss W.	Miss W.
	WED.	6-3	3	2	2	–	Bernice H.	Pneumonia.		Medications at 6 p.m.	Medications at 6 p.m.
	THUR.	Day				–	Francis P.	Leukemia.		Bernice — nose treatment at 6 p.m.	Bernice — nose treatment at 6 p.m.
	FRI.	6-3	10	2	2	–				Force fluid. Routine care.	Force fluid. Routine care.
	SAT.	6-3		2	2	–					
	SUN.	Day				–					
	MON.	6-3				–					
Miss W.	TUES.	7-3:30		2	1	–	Elizabeth McK.	Hematuria	Tidiness of ward.	Miss S.	Miss S.
	WED.	7-12 3:30-7		1	1	1	George R.	Otitis media.		George — dry wipe left ear. General care	General care.
	THUR.	7-3:30		1	1	–	André L.	Pneumonia.		Elizabeth — measure intake & output.	Medications at 2 p.m.
	FRI.	7-3:30	10-12	2	2	–			Solutions.	André is for discharge	
	SAT.	Day.				–				M. W.	
	SUN.	7-3:30		2	1	–					
	MON.	7-3:30		2	1	–					
Miss H.	TUES.	3:30-12	4:30	–	–	2	Paul P.	Chorea.	Linen cupboard	Miss R.	Miss R.
	WED.	10-7		1	1	1	Geo. P.	Rheum. Infect.	Medicine "	Routine care. Paul —	Routine a.m. care.
	THUR.	7-3:30		1	1	–	Jean C.	Hodgkin's Dis.	7 a.m. linen.	medication at 2 p.m.	
	FRI.	7-12 3:30-7		1	1	1				Jean — Extra care to mouth and back.	
	SAT.	7-3:30		1	1	–				A. H.	
	SUN.	7-3:30		1	1	–					
	MON.	Day.				–					

Interesting People

Unique in the annals of nursing in Canada is the appointment of a public health nurse to be the director of a great school of nursing. **Mary Seabury Mathewson, B.S.,** who is respected by hundreds of public health nurses for her splendid teaching ability as assistant director of the McGill School for Graduate Nurses, has been appointed director of nursing at The Montreal General Hospital.

Born and educated in Montreal, Miss Mathewson obtained her teacher's certificate from Macdonald College and taught for five years before entering The Montreal General Hospital School for Nurses to receive her training. Upon her graduation in 1925, Miss Mathewson engaged briefly in private duty before becoming supervisor in the operating-room at M.G.H. In 1929, having secured her certificate in public health nursing from the McGill School for Graduate Nurses, she joined the staff of the Child Welfare Association in Montreal. In 1933 she became a supervisor with that organization and commenced her teaching at McGill on a part-time basis. After 1938 she devoted her full time to the work as assistant director with the McGill School for Graduate Nurses.

Miss Mathewson has always given very generously of her time and energy in the interests of the professional organizations. She was president of the M.G.H. Alumnae Association for four years. She was secretary of the Public Health Section, C.N.A., secretary of the Provisional Council of University Schools and Departments of Nursing from its inception until this year. As convener of the History of Nursing Committee, C.N.A., Miss Mathewson directed the accumulation of the varied data which were vital to a true picture of the development of nursing and collaborated with John Murray Gibbon in the preparation of the book. She has been chairman of the Editorial Board of *The Canadian Nurse* since 1944.

In the activities of the provincial association, Miss Mathewson has played an important part. She has been chairman of the Board of Examiners since 1940 and first vice-president of the R.N.A.P.Q. since 1942.

With all of this activity, Miss Mathewson has found time for out-of-doors hobbies, gardening being her chief delight.

Helen Griffith McArthur has been appointed as the first national director of nursing with the Canadian Red Cross Society.

Alberta has been the scene of most of Miss McArthur's activities. She graduated from the University of Alberta Hospital in 1933 and received her Bachelor of Science degree from that university, majoring in public health nursing, the following year. She joined

Notman, Montreal

MARY S. MATHEWSON

Goerts, Edmonton

HELEN McARTHUR

the staff of the Foothills Health District, High River, as senior nurse. Three years later, she entered the service of the Alberta Department of Health to engage in rural generalized public health nursing. Since this service is to outlying districts where no medical practitioner is available and includes complete morbidity and maternity service as well as the preventive program, these two years provided a very clear insight into rural problems.

After securing her Master's degree in supervision and teaching from Columbia University in 1940, Miss McArthur became acting director of the school of nursing at the University of Alberta. In 1944, she was appointed superintendent of the public health nursing branch in the provincial Department of Public Health.

Miss McArthur has been exceedingly active in nursing organization work. She has served as president of the University of Alberta Hospital Alumnae Association, first vice-president of the Alberta Association of Registered Nurses, chairman of the Public Health Section, C.N.A., since 1944, and chairman of the Public Health Nursing Section of the C.P.H.A., to mention only a few of her major activities. Her abilities will be given wide scope in her new work.

Jean Shanks Clark has been appointed director of the public health nursing branch of the Provincial Department of Public Health in Alberta.

Miss Clark won the gold medal when she graduated from the University Hospital, Edmonton. She obtained her B.Sc. degree in nursing from the University of Alberta in 1941. Following graduation, she engaged in rural public health nursing work. In 1942 she joined the staff of the Calgary Health Department. She was on loan for a year to the A.A.R.N. and served as travelling instructor throughout the province.

In 1945 Miss Clark was awarded a Rockefeller Fellowship which entitled her to special study leading to her Master's degree in Public Health at the Johns Hopkins School of Hygiene and Public Health. At the conclusion of her course there, she had the opportunity to observe public health activities in various centres for a period of three months.

Miss Clark has served as chairman of the Alberta Public Health Section and was secretary of the Public Health Section, C.N.A. She is a member of the Women's University Club. For relaxation she turns to needlework and sewing. We shall look for great things from Miss Clark in her new position of leadership.

Goerts, Edmonton

JEAN S. CLARK

Mary Elizabeth Reed, A.R.R.C., has been appointed as National Office supervisor with the Victorian Order of Nurses for Canada. Born and educated in Saint John, N.B., Miss Reed graduated from the General Public Hospital there in 1929. Prior to enlisting with the R.C.A.M.C. in 1942, Miss Reed had twelve years of staff and charge work with various branches of the Order in the Maritimes. She received her certificate in public health nursing from the McGill School for Graduate Nurses in 1939.

ELIZABETH REED

MATILDA DEVERE

Miss Reed went overseas with No. 21 Canadian General Hospital. She saw active service in France. Later she was attached to C.M.H.Q. in London on the matron-in-chief's staff.

The qualities of leadership which Miss Reed has shown make a particularly good background for the added responsibilities she is now assuming. We wish her success and happiness in her new duties.

Matilda Newcomen DeVere, who graduated from The Montreal General Hospital in 1923, has recently assumed her duties as superintendent of nurses at the Saguenay General Hospital, Arvida, Que. Following graduation, Miss DeVere engaged in private duty in Montreal, California, and New York.

In 1941 she enlisted with the R.C.A.M.C. and saw service in many parts of Canada and aboard the hospital ship, *Lady Nelson*. Miss DeVere is very interested in music, particularly vocal music. The fact that she is completely bilingual will be a valuable asset to her in her new work since the hospital serves both English and French-speaking citizens.

Notman, Montreal

MABEL K. HOLT

Hildur K. Hermanson, a native of Sweden, who graduated in 1929 from St. Paul's Hospital, Saskatoon, has been lent by the Board of the Women's Missionary Society of the Presbyterian Church in Canada to re-establish the school of nursing in the Mackay Memorial Hospital, Taipeh, Formosa, under the auspices of the Chinese War Relief. Miss Hermanson had served as superintendent and instructress of nurses in this hospital for eight years while Formosa was under Japanese control.

Miss Hermanson enrolled for the missionary and deaconess course at the Presbyterian Deaconess School. She secured her midwifery training in London, Eng. Her first appointment was to the Canora (Sask.) Presbyterian Hospital. After she was forced to leave Formosa, she served for five years as superintendent of Rocky Mountain House (Alta.) Hospital, a Presbyterian Mission Hospital. See the account Miss Hermanson has written on her return to Formosa in the "Letters from Near and Far."

Well known all over Canada for her contributions to nursing, **Mabel Kathleen Holt** has retired from The Montreal General Hospital where for nineteen years she has been superintendent of nurses and principal of the school for nurses.

Miss Holt was born and educated in England. She graduated from The Montreal General Hospital in 1919. After taking the course in hospital administration at the McGill School for Graduate Nurses, she returned to her own school of nursing as instructor. She served for two years as assistant superintendent of nurses at the Hamilton General Hospital, going to the position which she has held with honor for so many years, in 1927.

As president of the Registered Nurses Association of the Province of Quebec from

1928-32, Miss Holt guided the activities with a sure hand. She has remained an active member of the Board of Management throughout the years. She has been a member of the Advisory Board of the McGill School for Graduate Nurses. She has served in various capacities in the work of the C.N.A., her most recent convenership being for the Exchange of Nurses Committee. Varied interests other than professional have provided outlets for Miss Holt's interest. An ardent reader, she is a member of the McGill University Book Club. She has maintained her interest in the fine arts through her membership in the Art Association of Montreal. Now in her retirement to Prince Edward Island, Miss Holt is leaving behind the profession which owes her much for her enlightened and farsighted leadership. She will be long remembered by the hundreds of graduates who have come from her school as a loyal friend, a kindly mentor. We wish her great happiness in the coming years.

Winnifred Dawson, who has rendered outstanding service to the Victorian Order of Nurses for Canada for the past sixteen years as eastern supervisor, has resigned from the National Office staff and plans to retire from active nursing.

Born in Mt. Forest, Ont., Miss Dawson taught school in Saskatchewan for two years before enrolling in the school of nursing of the Winnipeg General Hospital. Following her graduation in 1914, she filled supervisory positions in the operating-room at the W.G.H. until her enlistment in 1917 with the C.A.M.C. In 1921 she received her certificate in public health nursing from the University of Toronto School of Nursing. A few months of staff duty with the Department of Public Health in Toronto and she was set for new adventures. Under the joint sponsorship of the Rockefeller Foundation and the Federal Department of Health for Brazil, Miss Dawson spent six years in Rio de Janeiro establishing public health nursing service as supervisor of the Demonstration Centre for Public Health. During this time she was afforded an opportunity of indulging in her favorite sport of mountain climbing. She can proudly claim to have made the ascent of "Itatiaya," the highest peak in Brazil.

In 1928, Miss Dawson returned to Canada and rejoined the Toronto public health nursing service. In 1930, she joined the supervisory staff of the Victorian Order of Nurses.

WINNIFRED DAWSON

She has done invaluable work in promoting the extension and development of the Victorian Order and her retirement will be a real loss to the organization. Possessed of a genuine liking for people and a sincere interest in their welfare, she won from professional and lay groups alike support and respect for the organization and personal affection.

A person with many interests and with a host of friends far and near, Miss Dawson is looking forward to the opportunity of travelling before settling down. Our warmest thoughts go with her for many years of happiness.

As intimated in the July, 1946, issue of the *Journal*, **Gertrude M. Bennett** has completed her work as director of nursing at the Ottawa Civic Hospital and now retires to live in British Columbia near her niece whose three small children are the joy of Miss Bennett's heart.

The hundreds of nurses who received their training under Miss Bennett will remember her always for the high ideals of service, duty, and citizenship which she instilled into them. Wishing to encourage the development of the younger members of her staff, Miss Bennett unselfishly adopted the policy of remaining on the job while her assistants benefited from the contacts at conferences and conventions. Nevertheless, her statesmanlike influence has spread over the local district and on to the deliberations of the provincial organization. Miss Bennett has been chairman of District 8, R.N.A.O.; second vice-president of the C.N.A. and for many years a member of the Council on Nursing Education for Ontario.

Obituaries

Mrs. Mary E. (dePencier) Goodwin, who graduated with honors from the Kingston General Hospital in 1895, died September 3, 1946, at her home in Burritt's Rapids, Ont., at the age of 89 years. Mrs. Goodwin had served as superintendent of nurses at Rockwood Hospital, Kingston; the General Hospital at Belleville; St. Luke's Hospital, Newburgh-on-Hudson, N.Y.; and until her retirement to be married in 1911 she was superintendent of nurses at Aultman Memorial Hospital, Canton, Ohio.

Frances Grigg, Reg. N., was drowned while boating on the Ottawa River.

Margaret Stearns Jones died in St. Stephen, N.B., following several months of failing health. A graduate of Deaconess Hospital, Boston, Miss Jones engaged in social welfare work there and then went to India as a mission nurse for a period. She retired from active nursing ten years ago.

Ruby McLaren, a graduate of McKellar General Hospital, Fort William, died recently after a long illness. Miss McLaren had engaged in private nursing prior to her illness.

Loraine Morrison, who for fifteen years had been superintendent of the I.O.D.E. Hospital for Convalescent Children, Toronto, died recently in Kincardine, Ont. Miss Morrison was a graduate of the Hospital for Sick Children, Toronto. She had worked in the Children's Hospital, New Haven, Conn., and in the Shriners Hospital and Children's Memorial Hospital, Chicago. Returning to Canada, she took the course in administration at the School of Nursing, University of Toronto, before going to the I.O.D.E. Hospital.

Elizabeth Jean Oliver died on September 3, 1946, at the Women's College Hospital, Toronto, where she had graduated this spring. Miss Oliver suffered very severe burns in April as a result of an accident while she was on duty as a student. Critically ill, she was awarded her diploma and pin while on her sick bed.

Maud E. Pearce, a former resident of Newton, N.B., died suddenly in New York where she had been engaged in nursing for a number of years.

Reverend Sister Mary Eileen of the Order of St. Joseph's, who has been a member of the staff of St. Joseph's Hospital, Estevan, Sask., died in the hospital on September 19, 1946, following an illness of three months.

Ontario Public Health Nursing Service

The following are appointments to the Ontario Public Health Nursing Service:

Merle Frank (Victoria Hospital, London, and University of Western Ontario certificate course), formerly with the British Columbia Department of Health, to the Welland-Crowland health unit; *Barbara Wood* (Kingston General Hospital and University of Toronto certificate course), formerly with the Hamilton Department of Health, to Leaside Board of Health; *Marion Monck* (Hamilton General Hospital and University of Western Ontario certificate course) to Bruce County health unit; *Miriam MacDonald* (Toronto Western Hospital and University of Toronto certificate course), formerly with the Toronto Department of Public Health, as senior public health nurse with North Bay Board of Health; *Frances Winchester* (Massachusetts General Hospital; McGill School for Graduate Nurses certificate course and B. Sc. in nursing) to Elgin County health unit; *Clara Kittmer* (Woodstock General Hospital and University of Western Ontario certificate course) as public health nurse with Boards of Health of the Village of Ayr and the Townships of North Dumfries and Wilmot; *Mrs. Margaret Greenwood* (Vancouver General Hospital and University of B.C. certificate course) to Etobicoke Township Board of Health nursing staff; *Andrée Soulières* (University of Ottawa undergraduate course and McGill School for Graduate Nurses certificate course) to Ottawa Board of Health.

STUDENT NURSES PAGE

Nursing Ethics

Editor's Note: Every student nurse receives instructions in nursing Ethics early in the probationary period. The following article is a composite of the answers received on the topic, "Why I think Ethics is an important subject in the nursing curriculum; how it has helped me and how I have been able and will be able to apply it in my work in nursing." The eleven students from the Belleville General Hospital, whose comments comprise this article, are: Erma Chambers, Muriel Coyle, Vivian Craig, Eleanor Fellowes, Jean Kelly, Lois McLean, Lois N. Peacock, Doris Platt, Elizabeth Rutherford, Olive Smith, Ruby Wilce.

A definite code of ethics has been set up for every profession. Before a nurse can progress any distance on the road leading to the life she has chosen, she must measure up to ideals, customs, and habits already set up for this profession. Preliminary students enter a school of nursing with both desirable and undesirable habits. Ethics helps the student to retain her good habits, abandon the poor ones, and build a foundation for other desirable ones.

To stress the importance of Ethics in a few short paragraphs would be like trying to fathom the depths of an ocean; however, by examining a bit of each we are able to visualize what lies beneath. It is like seeing a goal which lies afar off, where exists perfection, and only by striving and studying for that goal are we able to attain and maintain a hospital atmosphere, with professional services and courtesy as the pillars, loyalty and trustworthiness the framework, and Ethics the foundation.

Nursing is a great and noble profession. It involves two principles — that of technical service and that of personal conduct. An individual may be quick to grasp technical skills but be lacking in ethical training and no matter how successful the technical training may be, a nurse without Ethics is like a ship without a rudder. We are self-creators but we must be moulded with care, just as a great sculptor carefully moulds a figure, if we are to represent what is essential and expected in a nurse — good moral conduct and suitable attitudes.

Each day a student nurse's life is filled with numerous incidents which she may meet adequately providing her character and habits are those best suited for nursing. But there are so many novel situations that she has never had an opportunity to become even partly familiar with, that a knowledge of Ethics will often be her only true and reliable guide.

The statement has been made that a nurse's personality is as important as her nursing skill and technique. This is definitely true. The elements needed to make a good nurse are found in her character. She must conduct herself so that her patients and the patients' families have confidence in her and in her judgment and care. To be able to successfully carry out a nursing procedure is only a very small part of a nurse's responsibility. She must be able to carry it out in such a way that the patient will receive the greatest benefit. To win a patient's confidence is the nurse's first step in helping to win back his health. And it is this patient's confidence that a study of Ethics shows

us to be the nurse's sacred trust. So much depends on her ability to do and say the right thing at the right time for the patient's well-being, her own security, and the good name of her hospital. Any knowledge that comes to her from a patient, his friends, or his relatives is hers to keep.

Ethics has helped us to take a broader outlook on life. It has helped us to better understand our selves and our co-workers. We have learned that it is not only satisfying to be courteous, kind and helpful, but it also helps to improve and raise the hospital and residence spirit and morale. By trying to be pleasant, happy and satisfied, we have found it easier to adapt to the entirely new life which we have found in residence.

Ethics teaches the importance of being careful to prevent hospital accidents and it emphasizes the necessity for constant watchfulness. It teaches that we must have the right attitude toward rules and regulations. Rules in a training school are all made for a logical reason and every student should endeavour to see the rules from the standpoint of those in authority. A study of Ethics tries by colorful examples to show the student the reasons for her careful observance of the rules. Loyalty is demanded of every girl entering as a student nurse and loyalty begins with observance of rules. This study points out the various ways in which we may be loyal to our institution.

Too much stress cannot be laid on honesty. It cannot be taken for granted as a common characteristic of the majority of normal individuals. Petty dishonesty cannot be brushed lightly aside as a mere matter of convenience for dishonesty in any form is a breach of the most fundamental law of Ethics. You cannot be a fit person to handle the affairs and lives of others when you have no conscience about ignoring irksome tasks or helping yourself to what you think you want or need. Dishonesty has many different forms and some acts, which to a student may seem very innocent, are sometimes not strictly honest. The study of Ethics tries to develop a nurse's conscience.

Ethics has made us see the necessity for having a broad outlook on life. It has helped us see the necessity for discretion, accuracy, tactfulness, steadfastness, courage, kindness, tolerance, and self-confidence in daily nursing. Ethics has helped us to be better able to face disappointment and sorrow. We must keep our feelings to ourselves and remember "actions speak louder than words." Through the study of Ethics we have been able to adjust to new situations and to adapt to strange circumstances. We have learned to readily accept and appreciate criticism.

Ethics has given us an entirely new conception and understanding of what is expected of a nurse. Hers is no routine job. There is so much more at stake than just her own personal ambitions and gain. She will come in contact with scores of human beings, and they will leave her, benefited not only by her nursing care but by her patience, sympathy, understanding, even by her outlook on life, if she is the kind of a nurse she should be. She has a great responsibility. A nurse must know Ethics, believe in Ethics, and stick by Ethics in every conscious moment of her day. Ethics isn't just something that prompts us to stand in the presence of our seniors, and not tell Mrs. Jones that her next door neighbor has syphilis, or pilfer grapes from the ice-box. It directs our whole lives, our every action, it clears our confusion and keeps us headed on the right path — up.

In future work — no longer sheltered and directed by the school of nursing, when decisions are in our own hands and when we have only ourselves to tell us what is right and what is not — then will be the real testing time of Ethics. Our success then will depend on Ethics; we will have the knowledge and the skill, but only the ethical nurse can drive through to fulfill her ambitions and reach her goal and, in doing so, do her small share.

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Letters from Near and Far

In Formosa

Formosa has been so difficult to get to lately that my Church Board (the Presbyterian W. M. S.) could not make any plans for my return. When the Chinese War Relief Fund (headquarters at Bay St., Toronto) asked to borrow me for a year the Board and I agreed as they hoped to send me here to help re-establish the work in the Mackay Memorial Hospital. When the final plans were completed there was a grand rush as I had to arrange my work and get packed, inoculated, etc., within about three weeks. We were to sail from Seattle on April 25 and finally got away on the 30th, arriving in Shanghai on May 15. We were on a navy transport which, for the first time, carried passengers, and everything was disorganized at first but we had quite a good crossing. I had hoped to proceed directly to Formosa, but there was no available space on the little boats going there. I was able to send my trunks with a friend who had a booking on a boat to Fuchow and who hoped to get here by some means or other from there. He finally managed to get a small boat from Fuchow with standing room only, but managed to get my trunks on. I then tried to get a plane, but for the first while all flights were booked for Chinese government officials and then the planes went on strike for three weeks, (or rather their ground crews did). After a month in Shanghai, I finally got a plane over, which was very pleasant and took only three and a half hours. It was a beautiful day and Formosa looked like a jewel as seen from the air.

I arrived to find that the Chinese soldiers

were still in our hospital and mission houses. A kind Formosan lady, who used to teach in our mission schools, asked me to stay with her and I am still with her. After a lengthy talk with the head of the army we finally got the soldiers out of the hospital and it is now being repaired and cleaned, but they are still in our houses. The new government had confiscated all our medicines and instruments and, of course, the soldiers had ruined everything they did not steal, so the place just made me weep when I first saw it. We have been trying to get some of the things back or replaced. At first the Department of Health said "certainly", but now it seems they have nothing! The new regime is a bit difficult. In the meantime I am busy with committee meetings and seeing scores of people who come to see if the hospital is soon to be opened. The need here is very great; there is so much illness and everything is so expensive. Medicines are all a monopoly or something, so people cannot get them except by paying fantastic prices. The Christian Formosans, however, are very anxious to have me help open the place and are trying every method known to get some supplies. The place was used by the Japanese during our absence and, of course, during a war nothing is painted or repaired so everything is a mess.

While I was waiting around to see what could be done about the hospital, UNRRA asked to borrow me for a project of theirs. None of their members speak Formosan so it is very hard for them. Formosa has a terrific number of cholera cases and as cholera is new to the Formosans they have no idea what to do and numbers were dying every day. UNRRA sent their nurse and a doctor to see what they could do and I went along to help talk. They also had a Formosan nurse who had trained in St. Luke's in Tokyo and who speaks English. We arrived there to find the patients lying on the floor of the so-called isolation hospital in the most indescribable filth. There were three nurses and one doctor in the hospital. The nurses took temperatures, swabs, and did charts. Relatives cared for the patients and all their belongings, cooking utensils, dishes, and bedpans were on the floor with the patients. You can imagine the filth with the flies swarming all over! We got permission from the municipality to have some of their nurses. In their hospital there were thirteen patients, forty nurses, and fifteen doctors — (of course, they have out-patients too). We ended up by having eight of the nurses and put them on shifts. Then we found that the army had some beds that rightly belong to the isolation hospital so we went there and got some beds from them. Then we got gowns, sheets, and soap from UNRRA and bought wash basins, set up a sort of isolation technique and the mayor saw to it that the patients could get food. But first of all we had to clean up the place which meant that *we* did a major part of the scrubbing. The heat was terrific and the patients were so dirty that we had to clean them to exist! We also set up intravenous sets and our doctor persuaded the resident doctor to use them. He became quite interested when he found that patients so treated lived!

The UNRRA nurse is a Canadian, Helena Reimer, of Winnipeg, and the association can be very proud of her. She is doing a magnificent work. I could stay only one week as they needed me here, so the others of the team carried on. When she felt she had taught the nurses enough to carry on they took two of them along and went on to two other places to set up the same ideas. Miss Reimer, as you know, is a grand person and I did enjoy working with her so much.

— HILDUR HERMANSON

It is Not Easy

To apologize
To begin over
To admit errors
To be unselfish
To take advice
To be charitable
To be considerate
To keep trying
To avoid mistakes
To forgive and forget
To keep out of the rut
To make the most of a little
To maintain a high standard
To recognize the silver lining

But it Always Pays!

Book Reviews

Essentials of Body Mechanics in Health and Disease, by J. E. Goldthwait, M.D.; L. T. Brown, M.D.; L. T. Swaim, M.D.; J. G. Kuhns, M.D. 337 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 4th Ed. 1945. Illustrated. Price $6.00.

Reviewed by Jessie Cook, Instructress, Royal Victoria Hospital School of Nursing, Montreal.

This text, first published under the title of "Body Mechanics in Health and Disease", has been completely revised with considerable new material added. The first three chapters deal with body types and susceptibility to disease, the meaning of body mechanics, and the need for studying the individual and his type of anatomy in order to prevent deformities, malfunction, and permanent damage to organs.

Chapters 4 to 14 deal with various conditions resulting from faulty body mechanics with an outline of means of prevention and correction. Interesting case reports, x-ray findings, tables, pictures, and diagrams serve to illustrate the points discussed. The authors state that prolonged faulty use of the body is one of the most vital factors in the production of chronic disease and stress the value of early training.

The book ends with a discussion of the important part played by good body mechanics in helping the older members of society to remain happy and useful as long as possible.

A bibliography offers a wide range of suggestions for those interested in further reading. Instructors and other graduate nurses should find this book both interesting and profitable.

Nursing in Commerce and Industry, by Bethel J. McGrath, R.N. 356 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. 1946. Price $3.00 (in U.S.A.).

Reviewed by Frances Harris, Consultant, Industrial Nursing, Department of National Health and Welfare, Ottawa.

"Nursing in Commerce and Industry" meets a widespread demand for an authoritative text on industrial nursing. Nurses in universities, preparing for the generalized course in public health nursing, will find this text especially useful. Nurses who have entered industry without special preparation will appreciate the fundamental information contained in this book. Suggestions are practical and can be adapted to fit particular cases. The chapters on Equipment and on Records and Reports, and the outline for the Manual of Policies and Procedures, are worthy of special mention. However, the book is definitely not just a nursing textbook. Many persons with a wide variety of skills are closely allied to the nurse in industry. Physicians, safety engineers, and personnel workers will find the book valuable and enlightening. In the chapter discussing relationships within the industrial plant, one senses that the writer has first-hand knowledge of her subject. Bethel McGrath's interpretation of the philosophy and practice of industrial nursing should enable executives interested in the promotion of industrial health programs to make more effective use of existing nursing services.

Psychology for Nurses, designed and written for student nurses, by Bess V. Cunningham, Ph. D. 336 pages. Published by D. Appleton-Century Co. Inc., New York. Canadian agents: The Ryerson Press, 299 Queen St. W., Toronto 2B. 1946. Illustrated. Price $4.00.

Reviewed by Kathleen Marshall, Allan Memorial Institute, Montreal.

This book, written by a faculty member of the University of Toledo, is the result of many years' experiences of teaching psychology to student nurses. The author defines her attitude toward the whole topic in these words: "My viewpoint is still that of one who stands on the side looking in but with eager interpreters at my side." The text closely follows "The Curriculum Guide for Schools of Nursing" and is designed for use by the student.

The early chapters deal with the student nurse—why she comes to the school, what she brings with her, the learning problems which confront her, and what lies ahead. The

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nurse and her patients are discussed throughout a whole chapter and these complete the overall picture of the course, from which the author then develops the study of everyday psychology with its special application to nursing. The author states, "Long years of experience with college students in other fields has convinced me that students need help in applying almost any general course. Because of this conviction, I have tried to make psychology a practical science."

Reaction to strain and frustration in everyday living is very well described and the application of helpful suggestions for counteracting these irritants to the patient in hospital, and the nurse in her role of companion and helper, is one of the highlights of the book. Each chapter is summarized and, so that the student can obtain more satisfaction, a list of reading references, notebook suggestions, and suggested activities follow.

An Experiment in Mutual Understanding. 182 pages. Published by Registered Nurses Association of the Province of Quebec, 1012 Medical Arts Bldg., Montreal 25, P.Q. 1946. Illustrated. Price $1.25 postpaid.

Reviewed by Ethel Johns, former editor of "The Canadian Nurse."

On February 14, 1945, the Registered Nurses Association of the Province of Quebec celebrated its twenty-fifth anniversary. To mark this happy occasion, E. Frances Upton, for sixteen years its indefatigable executive secretary and registrar, was asked to write the history which now appears in pamphlet form under the apt title of "An Experiment in Mutual Understanding." As a result, an inspiring and authoritative record of professional solidarity may now be added to the history of nursing in Canada.

As Miss Upton herself suggests, this happy state of affairs is due to the patient and untiring efforts of many nurses of goodwill and keen intelligence in both the English-speaking and the French-speaking groups, who, through the years, have consistently striven to achieve and to maintain a sympathetic understanding between them. Thumbnail sketches are given of the successive presidents and other officers who shared the common task but, with characteristic modesty, Miss Upton omits to mention the woman who

made the greatest contribution of all.

A chapter, entitled "Echoes", gives the highlights of successive years and a most amusing description of the eventful meeting in 1929 of the International Council of Nurses at which Miss Upton won her spurs. The annual reports presented by Miss Upton are, in themselves, a running history of the association. The full text of her report for 1945 is no exception and gives an excellent picture of the current activities of the association. Incidentally, it also affords an amusing example of Miss Upton's capacity for humorous invective which never fails to hit the mark:

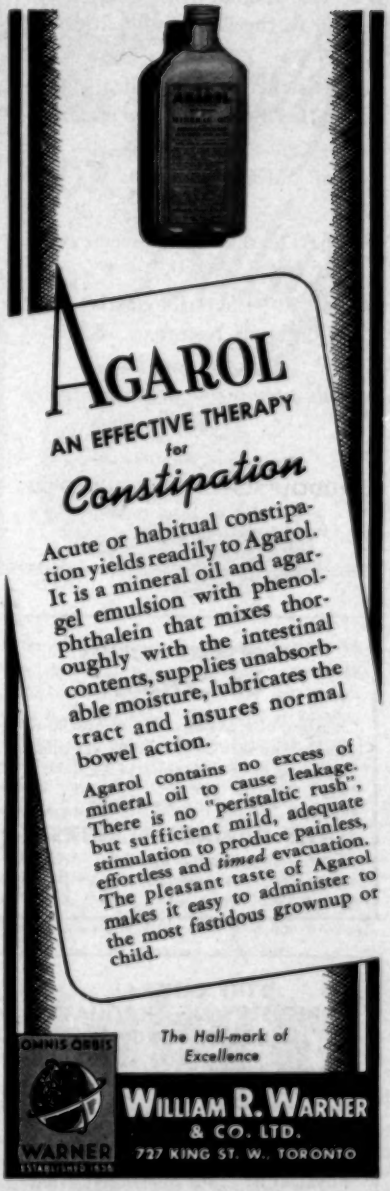
"Each month of our twenty-fifth year brought new problems to solve and new duties to perform but none of them could compare with December. New Year's Eve, you may remember, came on a Saturday. Well, that signified (a) the last day of a month, (b) the last day of a year and (c) *a Saturday*. Yet in spite of the fact that, under ordinary circumstances, seasonal activities and responsibilities would have necessitated long hours of duty at headquarters, no less than 120 members paid a personal call to headquarters on that particular day to pay their fees for the year then *in extremis*. To offset this *enthusiasm*, we must record that 1078 members *ignored us entirely* and at the end of the year were in arrears."

Nothing in our Canadian life is of greater importance than national unity. When we achieve it fully (and we shall) it will be because Canadians who work together for the common good come at last to understand one another. As she goes about her daily tasks, E. Frances Upton helps to interpret us to one another. Her knowledge of both languages, her unshakeable courage, and her unfailing enthusiasm have gone far to ensure the success of a notable experiment in mutual understanding.

Vingt-cinq Années de Collaboration, publié par l'Association des Gardes-Malades Enregistrées de la Province de Québec, 1012 édifice Medical Arts, Montréal 25. Prix $1.25 port payé.

Compte rendu par Soeur Allard, r.h., Hôtel-Dieu de Montréal.

L'Association des Gardes-Malades Enregistrées de la Province de Québec vient de présenter à l'attention de ses membres, et du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public en général, le résumé de ses vingt-cinq premières années d'expérience.

Le volume, intitulé "Vingt-cinq Années de Collaboration," se présente agréablement dans sa tenue bleu clair et on le parcourt d'un seul trait.

Le titre attesterait plutôt la réalisation d'un ouvrage collectif, alors que ce travail est bien le fruit de la vision nette de quelques âmes d'élite enthousiastes et progressives.

Avoir accompli dans un quart de siècle une tâche aussi magnifique dans un domaine où l'initiative reste le premier ressort, mérite, certes, toute notre admiration.

"Vingt-cinq Années de Collaboration" se divise en douze chapitres qui passent devant nous, telle une pellicule cinématographique, colorée et vivante. On y contemple à l'oeuvre les ouvrières de la première heure qu'il m'a été si agréable de revoir en souvenir: une demoiselle Hersey, Shaw, Samuel, Phillips, Clint, Chagnon, et combien d'autres. La lecture de ce livre nous fait assister au développement de l'association, grâce au zèle des continuatrices plus cachées, mais aussi combien méritantes, lesquelles, au cours de ces années ont consolidé l'oeuvre des devancières et en ont assuré le progrès et la prospérité. En parcourant le travail, on a la conviction que notre association provinciale d'infirmières a réalisé une oeuvre sociale solide et l'on est fier du statut légal et professionnel qu'elle vient de conférer à ses membres.

Pourrait-on aussi ne pas penser tout naturellement au travail acharné et à l'initiative pénétrante d'une demoiselle Upton? Dans toute oeuvre comme dans tout monument, il y a quelque part une âme dirigeante dont la clairvoyante activité assure la continuité de l'oeuvre.

Que serait, en effet, notre association provinciale, sans notre secrétaire-archiviste actuelle? C'est grâce à son dévouement éclairé et à son sens d'organisation rare que notre association occupe aujourd'hui une position si enviable.

Les pages de cette brochure nous révèlent les activités d'une association appelée à durer. Elles nous font exprimer le désir de voir l'idéal des âmes d'élite qui l'ont fondée, se transmettre, tel un héritage sacré, à l'infirmière d'aujourd'hui.

Que chaque infirmière fasse siennes les leçons du passé contenues dans ce volume afin d'assurer à notre association un progrès encore plus marqué au cours du deuxième quart de siècle.

News Notes

BRITISH COLUMBIA

Trail-Tadanac Hospital:

Additions to the nursing staff include Gertrude Martin, Kathleen Loucks, Dorothy Hamilton, Hazel Jamieson, and Helen Galucka. Mrs. Edith McGerrigle, a former member of the staff, relieved in the X-Ray department during the summer. Pauline Neville is on a three months' leave of absence. Alma McKerral recently left to be married.

Vancouver General Hospital:

The following nurses are taking the four-month course in operating-room technique: Irene Knight, Victoria (R.C.A.M.C.); Kathleen Lambert, Regina (R.C.A.M.C.); Urvilla Rutherford, New Westminster (R.C.A.M.C.); Constance Spall, Kelowna (R.C.A.M.C.); Helen G. Stewart, Forest Hill Village, Ont.; Hazel Wynne-Jones, Moose Jaw (R.C.A.M.C.); Olive Wilkinson, Kleecoot, B.C. (R.C A.M.C.). H. Mussallem and L. Maxwell are attending the McGill School for Graduate Nurses.

NEW BRUNSWICK

SAINT JOHN:

At meetings held by the Saint John Public Health Section during the past year the following doctors lectured: Dr. E. C. Menzies on mental diseases; Dr. W. O. McDonald on predisposing causes of present-day illnesses; Dr. Jos. Tanzman on pre-natal care. The final meeting of the season took the form of a dinner at Stoney Croft. The following officers will serve during the coming months: president, Muriel Clark (nurse-in-charge, tuberculosis clinic); secretary-treasurer, Mary Donovan (school nurse, district board of health); program committee, Beth Boulter (infant welfare nurse, district board of health), Eva MacDonald (tuberculosis clinic).

Margaret Pringle, formerly in charge of nurse placement service in Saint John, has been appointed supervisor of Red Cross outpost hospitals in New Brunswick. Beth Boulter, public health nurse of Toronto and Prince Edward Island, is now on the staff of the Board of Health to do infant welfare nursing in Saint John.

At a recent meeting of the Saint John General Hospital Alumnae Association, with Sue Hartley presiding, Marjorie Clarke and Kathleen Lawson, delegates to the N.B.A. R.N. annual meeting held in St. Stephen, presented interesting reports. The Rev. Mr. Martin entertained the members with motion pictures of Canada.

Mrs. Dorothy Eaton, a former member of the S.J.G.H. staff, is now resident nurse at Acadia University, Wolfville, N.S. Before leaving Saint John she was guest of honor at an afternoon tea. Alberta Hanscome is now assistant instructress of nurses at S.J.G.H. Margaret Darling, former public health nurse for King's Co., is now with the B.C. Provincial Board of Health.

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NOVA SCOTIA

HALIFAX:

His Excellency the Governor General of Canada, Viscount Alexander, accompanied by Her Excellency the Viscountess Alexander, on their recent trip to Halifax visited all local hospitals, including civilian, army, navy, and air force, and had special words of encouragement to the nurses as well as the patients.

Kathleen Dickson, former supervisor of public health nurses for Halifax, is now sering in a similar capacity with the City of Westmount, P.Q. Miss Dickson was the pioneer in organizing the nursing services of the Halifax Department of Health. Dorothy Wiswell is back home after four and a half years in the nursing services of South Africa and Egypt. Bell MacDonald is taking a post-graduate course in operating-room technique at St. Michael's Hospital, Toronto.

ONTARIO

EDITOR'S NOTE: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto 6.

DISTRICT 1

CHATHAM:

Public General Hospital:

At the opening meeting of the alumnae association, Mrs. Jean Goldrick, the president, was in the chair, Muriel Fletcher and Dorothy Thomas presented interesting reports of the convention held in Toronto. Plans were discussed for a bridge and tea, to be held later on in the year for the purpose of raising funds. Printed membership forms were on hand to be given to the new graduates. Mmes Eva Stacey and Ruby Sheldon served lunch.

QUEBEC

MONTREAL:

Royal Victoria Hospital:

Winnie Chute has left for India to join the staff of the Medical Missionary Hospital and College, Vellore, South India, where she will teach physiology and nutrition. Clara Preston has returned to China. (For more details on Miss Chute and Miss Preston please see the "Interesting People" page in our October, 1946, issue.) Elizabeth Hartig, who took the course in teaching and administration at the University of Western Ontario, has been appointed to the staff of the hospital in Rajamundry, Madras Presidency, India.

Doris Carter is school nurse at the Ottawa Technical High School. Marion Keith is assistant to the medical librarian and relief assistant in the nursing service administration office at the Children's Hospital, Halifax. Laura Rasmussen has joined the

Department of Health and Public Welfare, Manitoba, and is stationed at the Fisher branch, an outpost north of Winnipeg. Sara Powell is now on the staff of St. Luke's Hospital, Pangnirtung, Baffin Land, N.W.T. Margaret Lafontaine is nursing in New York.

Florence Gass, who attended the McGill School for Graduate Nurses last year, is with the teaching department. H. Adams is head nurse on the 4th floor, Ross Memorial, and Mildred Williams is in charge of Ward D.

Prior to her resignation from the staff as head nurse in the operating-room, Margaret Etter was honored at a reception given at the Faculty Club by the medical staff, including many of the surgeons she has assisted during the past years. Dr. Chipman and Dr. Miller were among those who spoke briefly. M. Warnock has succeeded Miss Etter and Violet Williams will be her assistant.

Christine MacIntosh has been granted a hospital scholarship to take the course in public health at the University of Western Ontario.

The following graduates are now attending the McGill School for Graduate Nurses and are taking the courses as indicated: Public health nursing — certificate course, N/S's W. Burwash, L. E. Wright, Mrs. M. E. Milligan; degree course (1st year), N/S C. MacKinnon; degree course (2nd year), N/S S. E. Mingie; teaching and supervision in schools of nursing — certificate course, N/S's B. E. Allen, E. C. Pratt, Misses C. E. Cook, M. I. Dolphin, D. J. Ford; degree course (1st year), C. M. Brown; degree course (2nd year), J. E. MacGregor, J. Thirlaway; supervision in obstetrical nursing, Emma Scott. Misses Cook, Ford, and Dolphin are attending on hospital scholarships.

Recent visitors to the school included: Miss Beck-Friis, director, Nursing School-Clinic, Swedish Red Cross; Miss Holmgren of Norway; Miss Rengressy, director of nursing, Leland Stanford University, Calif.; Pauline Neville of Trail, B.C.; Mrs. F. L. (Duder) Bradshaw of St. John's, Nfld.

SASKATCHEWAN

ESTEVAN:

A. Duculzeau has resigned her position at St. Joseph's Hospital for a vacation in Paris, France.

HUMBOLDT:

The following officers were recently elected by Humboldt Chapter, S.R.N.A.; president, Rev. Sr. Marcella; vice-president, Rev. Sr. Loretta; councillors, Rev. Sr. Dolores, Rev. Sr. Hildegarde; general nursing section, Teresa Bevan; hospital and school of nursing section, Rev. Sr. Perpetua; secretary-treasurer, Mrs. Grace Chamney.

Rev. Sr. Eleanor is making plans to organize a registry.

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MOOSE JAW:

The Moose Jaw Regional Health Centre now has a staff of six with Dr. G. Kinneard as medical health officer in charge and A. Normandin as senior nurse. Other members are J. Armstrong, J. Anderson, E. Orrell, D. Jones, and Mrs. F. Lillico. Misses Armstrong and Anderson served with the R.C.A.M.C. overseas and have taken a post-graduate course in public health nursing.

Mrs. J. (Webber) Koshnysh is instructress at Providence Hospital.

PRINCE ALBERT:

The following officers will serve for the Prince Albert Chapter, S.R.N.A., during the coming months: president, Mrs. E. Drake; secretary, Mrs. C. E. Meilicke; treasurer, F. Altmann. The nurses of Prince Albert are pleased to welcome back Estella Wood. Owing to the shortage of "specials", the registry has been temporarily discontinued.

The following nurses have been appointed to the Victoria Hospital staff: Mrs. D. Dance, assistant superintendent of nurses; V. Parker (five years in South Africa) and Miss Flewell, assistant instructors; J. Holmes, P. Boon. Miss Boon has recently returned from overseas.

REGINA:

Mrs. M. A. Stark has resigned as registrar, Regina registry, and secretary-treasurer, Regina Chapter, S.R.N.A., and has been replaced in both positions by Mrs. M. Davies. Eleanor Barton has taken over Mrs. Guthrie's position on the nursing staff, Regina City Health Department, the latter having resigned.

Regina General Hospital:

The following have been appointed to the nursing staff: P. Templeton, assistant night supervisor; M. McDonald, medical supervisor; Miss Waddling, assistant instructor; C. Palmer (completed the degree course at McGill University), instructor; M. Westgate, obstetrical staff; M. Robinson, supervisor, E.E.N.T. ward. Resignations from the staff include: E. England, D. Whitmore, and Beth Force, the latter to be married.

SASKATOON:

St. Paul's Hospital:

Forty new students registered at St. Paul's School of Nursing. Three new clinical instructors were also welcomed — M. Robinson, S. Leeper, and Miss Worobetz. Miss Hopkins, of the Department of Public Health, is once again with the poliomyelitis clinic.

The following were recent visitors to the school: Mrs. Carl (Goodall) Lind, Jr., of Minneapolis, who, with her husband, is leaving for Munich, Germany, where Dr. Lind is pathologist with the 98th General Hospital; Clara Jackson, travelling instructor, S.R.N.A., who gave advice and direction to

the clinical instructors; Mrs. F. (Hudek) Mooney.

Saskatoon City Hospital:

Thirty-two students were enrolled recently for the preliminary class.

Newly appointed members to the staff include: Mabel Quirk, obstetrical department; Mrs. I. Petrie, director of health service. V. Brown has left the staff to take the degree course in teaching and supervision at the University of Western Ontario. Pearl Smith has returned from overseas and is at Montreal Military Hospital. Ann Marshall is in Trenton, Ont., with the V.O.N. Joan Witney, recently discharged from the R.C.A.M.C., is now matron, Indian Hospital Norway House, Man.

SWIFT CURRENT:

At a meeting of Swift Current Chapter, S.R.N.A., Marie Young addressed the members on the course for nurses' aides which she is conducting under the auspices of the C.V.T. Miss Young served overseas with the R.C.A.M.C. and has completed a post-graduate course at the University of Toronto School of Nursing.

Mrs. June Fingarson, who has gone to live at Alsask, has been replaced by Mrs. Marie Nodge as president of the chapter.

Two Coats Better than One

In finishing furniture, as in any other type of paint application job, two thin coats are better than one thick one. The reason is simple, evolving out of the drying process of the varnish. When a heavy coat is applied, the surface varnish dries quickly and seals over, so that solvent is trapped underneath and the air can't get in to oxidize the oils. The entire drying process is interfered with, so that the varnish checks, or becomes brittle on top and spongy underneath.

A National Uniform

A new national uniform for public health nurses was shown by the National Organization for Public Health Nursing at the recent convention of the American Nurses' Association. It has been designed to enable the American public to recognize the public health nurse wherever they meet her as a friend of their good health. The organization has 11,080 individual members, 353 agency members, and branches in 21 states.

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By Nina D. Gage and John Fitch Landon. A valuable textbook for student nurses and their instructors. There are recently-added chapters on the Sulfonamides, malaria, encephalitis, penicillin, and the Kenny treatment. 525 pages, 58 figures, tenth printing, $4.00.

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By Grace M. Longhurst. "Miss Longhurst is to be highly complimented . . . This book will prove of valuable help not only to nurses, but to all who are engaged in the care and treatment of tuberculous patients." — Robert E. Plunkett, M.D., General Superintendent of Tuberculosis Hospitals, New York State. 307 pages, 83 illustrations, $4.00.

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Open to female residents of the Dominion of Canada. Preference for war service. Full particulars on posters displayed in Post Offices and National Employment Service offices. Application forms, obtainable at above offices, should be filed not later than **December 1, 1946,** with the Civil Service Commission at Ottawa, Ont.

Registered Nurses for General Duty at Vancouver General Hospital, British Columbia. State in first letter date of graduation, experience, reference, etc., and when services would be available. 8-hour day and 6-day week. Gross salary: $125 per month living out, with annual increases up to 7 years, plus laundry. 1½ days sick leave per month accumulative with pay. Employees' Hospitalization Society. Superannuation. 1 month vacation each year with pay. Investigation should be made with regard to registration in British Columbia. Apply to Director of Nurses.

General Staff and **Operating-room Nurses** at a salary of $100 per month plus full maintenance. 3 weeks' vacation with pay and $50 bonus at completion of each year of service. Pension Plan. One day sick leave with pay per month accumulative. Bus service to city street-car line. Apply to Supt. of Nurses, Toronto Hospital for Tuberculosis, Weston, Ont.

Public Health Nurses with agency specializing in Tuberculosis. Health education and case finding program. Home visiting and clinic duties. No bedside nursing. Experience in tuberculosis preferred but not essential. Nurses without Public Health training desiring experience in this field accepted on temporary basis. Apply to Royal Edward Laurentian Hospital, Dept. of Public Health Nursing, 3674 St. Urbain St., Montreal 18, P.Q.

Night Supervisor and **Assistant Night Supervisor** for 100-bed General Hospital in Western Ontario. Position open January 1, 1947. Apply, stating qualifications, experience, and salary expected, to Supt., General Hospital, Woodstock, Ont.

Public Health Nurses for Bruce County Health Unit. Salary: $1,500 to $1,800 according to experience, plus car allowance. Apply to W. S. Forrester, Secretary, Paisley, Ont.

Assistant Operating-room Supervisor for Victoria Hospital, London, Ontario. Bed capacity, 575. Good salary and full maintenance. Post-graduate and practical experience very desirable. Apply, stating school and year of graduation, age, details of experience, references, and date of availability for service, to Supt. of Nurses.

Supervisor of Nurses for Dept. of Public Health & Welfare, City of Halifax. Applicants should state age, training, experience, salary expected, and supply references. General supervisory work for 15 field workers doing general duty public health nursing. Apply to Allan R. Morton, M.D., Commissioner of Health & Welfare, City Hall, Halifax, N.S.

Instructress in Infectious and Tuberculosis Nursing for the City Hospital for Infectious Diseases and the Halifax Tuberculosis Hospital. These two hospitals are planning an affiliation with four nurses' training schools in the City of Halifax. Applicants should state age, training, experience, salary expected, and supply references. Apply to Allan R. Morton, M.D., Commissioner of Health & Welfare, City Hall, Halifax, N.S.

General Duty Nurses. Salary: $100 per month with full maintenance; $105 per month with full maintenance, while on night duty, which comes one month in each 4 months. 6-day week. 3 weeks' vacation with pay annually. Apply to Supt., Lady Minto Hospital, Cochrane, Ont.

Operating-room Supervisor, Pediatric Supervisor, Nursing Arts Instructor. Fully qualified. Full maintenance provided. Apply, stating qualifications, experience, and salary expected, to Lady Supt., General Hospital, Dauphin, Man.

Operating-room Nurses and Assistant Night Supervisor with knowledge of obstetrics. Full maintenance. Apply, stating qualifications and experience, to Supt. of Nurses, General Hospital, Saint John, N.B.

Assistant Superintendent of Nurses for the East General Hospital, Toronto, Ontario. 450 beds. Apply, stating qualifications and salary expected, to Supt. of Nurses.

Periodicity of Epidemics of Influenza

There are two known strains of influenza virus, A and B. All major outbreaks of influenza in recent years have been due to the A and B viruses, although there have been localized outbreaks of unknown etiology.

Epidemics of influenza A have occurred in the northern hemispheres during the fall and winter of the following years: 1932-33, 1936-37, 1940-41, 1943-44.

Epidemics of influenza B have occurred in the northern hemispheres during the fall and winter of the following years: 1935-36, 1939-40, 1945-46.

Since influenza A has, in the past, been epidemic at intervals of three and four years and, since the last epidemic was in the fall and winter of 1943-44, health officers should keep in mind the possibility of an outbreak this fall.

— *California's Health*

Diagnosis

One of the major difficulties in providing good medical care at the present time is the comparatively high cost of obtaining early and adequate diagnosis. Under health insurance, with all necessary diagnostic procedures paid for, the cost factor should no longer be a deterrent to the patient or his family physician, and the major problem might readily be that of providing diagnostic services. Inasmuch as out-patient departments, as we know them now, may be largely unnecessary (under health insurance) such facilities in larger centres might be converted to diagnostic clinics, staffed by medical experts who would be paid from the health insurance fund.

—*Health Study Bureau*

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On 2,000 calories per day people may become thin, but are relatively normal. When the intake averages less than about 1,400 calories per day an apathy or lethargy is evident and people look gaunt. On 1,000 calories people become very emaciated and many die.